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STATE OF THE STATES

Finding Alternate Routes

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FOREWORD

The past year has been fascinating for me. In January 2004, I became the director of The Robert Wood Johnson Foundation's State Coverage Initiatives (SCI) program—a position that has given me the opportunity to travel across the country and meet with many state officials who are working hard on the issue of the uninsured. I have enjoyed sharing what I have learned in so many states and seeing first-hand the diversity of perspectives that makes state health policy so exciting. In my discussions with policymakers, I have seen clearly that states are at the front lines of the struggle to expand health care coverage. I am encouraged by their ability to continue to look for solutions even in tough fiscal times.

State policymakers faced some familiar challenges in 2004. Health care costs continued to grow, premiums outpaced inflation and workers' wages, and the latest data showed a persistent increase in the number of uninsured. While some states began to emerge from the fiscal crisis of recent years, many others faced significant deficits. In all states, economic recovery was slow, and, at best, incomplete.

States also had to absorb some relatively recent changes on the health policy landscape. Interest in consumer-directed health care took off in 2004 with the creation of health savings accounts (HSAs) and interest continued among employers in using consumer-based approaches to control rising spending. However, the impact of these new products on state insurance markets remains to be seen. Medicaid leaders and State Pharmacy Assistance Programs also coordinated the recently legislated Medicare Discount Drug Card program and prepared to implement Medicare prescription drug coverage in 2006.

Despite their challenges, states continued to foster debate on strategies to expand health insurance. Some struggled to maintain coverage while balancing their budgets and others were able to expand coverage for the first time in years. *State of the States: Finding Alternate Routes*, summarizes these efforts and where states stand today.

While there were some glimmers of fiscal improvement, 2004 was not a particularly easy year for most states. Even with the presidential election behind us, there is still great uncertainty about where coverage fits on the federal agenda. Yet state policymakers continue to strive for progress. As Dale Carnegie once said, "Most of the important things in the world have been accomplished by people who have kept on trying."

SCI has a history of supporting states as they seek to expand coverage, and we are constantly trying to find new ways to assist policymakers—whether through improving our Web site (statecoverage.net), developing new products, convening state officials for group discussions, or working with state decision makers one-on-one.

We applaud your recent efforts and accomplishments and look forward to working with you in the coming year.



Alice Burton
Director, State Coverage Initiatives



EXECUTIVE SUMMARY

For the past three years, state officials have steered a tough course as they faced one budget cycle after the next characterized by declining revenues and spiraling expenditures. But in 2004, for the first time, financial conditions in many states showed some signs of improvement. Although states faced a combined budget shortfall of nearly \$40 billion for fiscal year (FY) 2005, that gap is half of what they faced a year ago.

Still, the consequences of the fiscal crisis that began in 2001 remained palpable last year, and the road ahead for states remains long and uncertain. A tepid economy and significant unemployment underlay a slow recovery in tax revenues, while growing financial responsibilities contribute to persistent budget shortfalls.

Despite their challenges, states worked hard last year to keep health care coverage on their agendas. Most endured another bad budget year without making deep cuts to their Medicaid programs. However, officials worry that the program cannot sustain the current rate of cost increases for much longer. A combination of surging costs, enrollment, and uninsured has created a “perfect storm” that has driven many Medicaid leaders to rethink the way their programs are structured and operate.

In fact, in light of stalled federal Medicaid reform efforts in 2003, officials in some states have used their own waiver authority to make significant changes to Medicaid, such as altering benefits, imposing co-payments, or implementing new rules on pharmacy use. Some states are considering other, more significant changes to Medicaid, many of which are still in the conceptual phase.

The Health Resources and Services Administration’s (HRSA) State Planning Grant program has been a tremendous coverage resource to states and U.S. territories for the past six years—and 2004 was no exception. For FY 2004, HRSA awarded more than \$13 million through nine new state planning grants, 17 continuation planning grants, and nine “pilot project planning” grants—a new type of grant that enables states to implement the options they developed through previous planning grants.

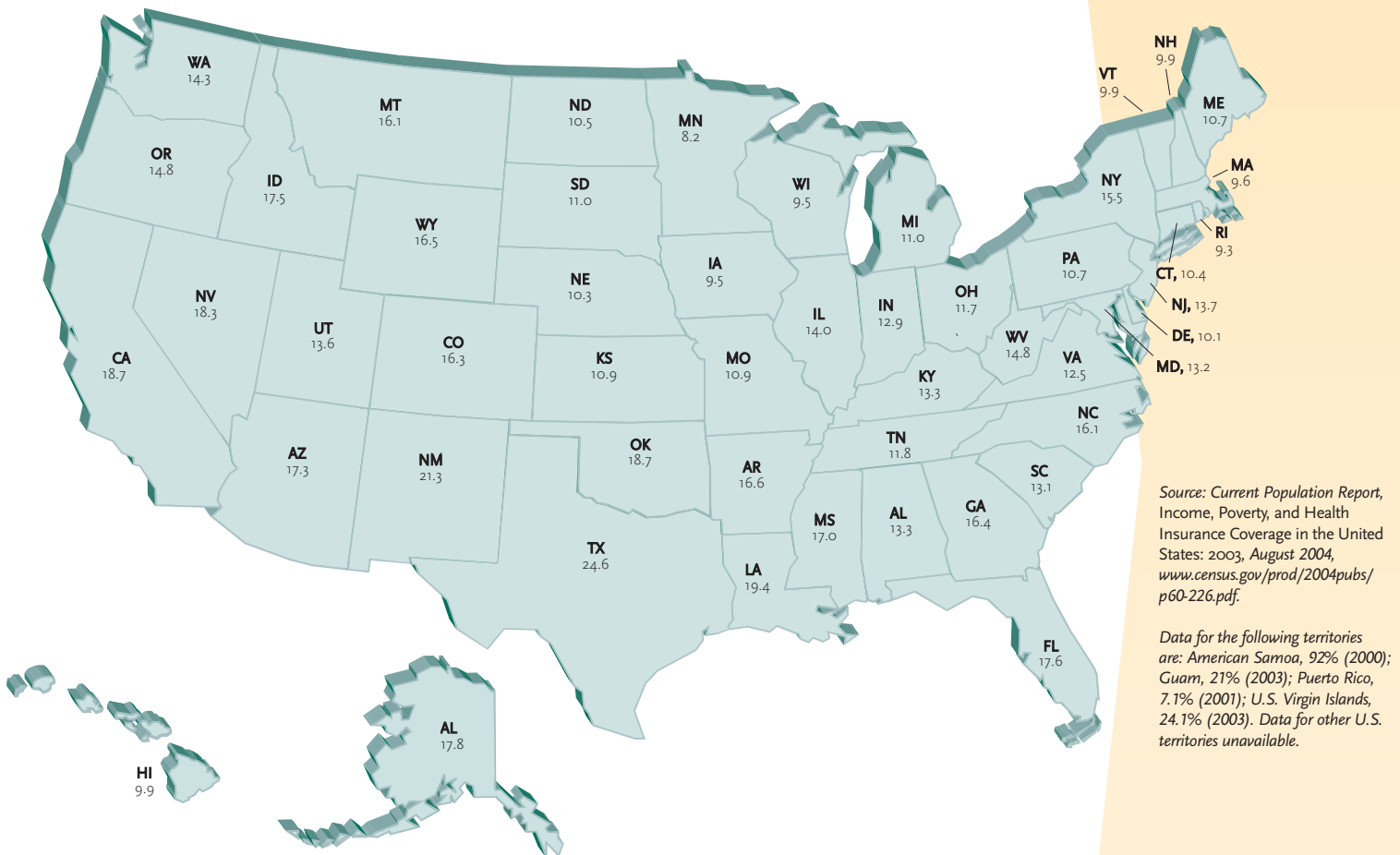
As for coverage expansions in 2004, a few states used the traditional strategy of expanding Medicaid and the State Children’s Health Insurance Program to new populations. Others continued to reach out to the private sector to build partnerships, with many seeking new opportunities for collaboration. Residents in several states voted on ballot initiatives that could increase health coverage. Regardless of states’ preferred approach, 2004 marked the first time in several years that many officials felt confident enough to look beyond stop-gap measures toward more comprehensive approaches to the uninsured.

Private insurers and employers across the country have also struggled with rising health care costs and the dwindling economy for the past several years, contributing to an erosion in private coverage. Private health insurance premiums rose 11.2 percent in 2004, according to an annual employer survey by The Kaiser Family Foundation and Health Research and Educational Trust. Although this rate of increase is less than that from 2003 (13.9 percent), 2004 marks the fourth consecutive year of double-digit growth.

Officials in some states took a hard look at the underlying reasons for private-sector cost increases and tailored their approaches to address them. Most state strategies focused on how to make insurance more affordable, whether through legislation to allow insurers to sell scaled-back benefits plans to small groups or revisiting the concept of state-sponsored reinsurance (in which the state assumes a portion of carriers’ high-cost claims).

State leaders were also tasked last year with sorting through the implications of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which for the first time provided seniors and people living with disabilities a prescription drug benefit under Medicare. States were most focused on how to partner with the federal government and private health plans to implement the Part D drug benefit, which will take effect in 2006, and the drug discount card and transitional assistance program, which began in June 2004.


Figure 1: Percentage of People without Health Insurance by State, 2001–2003 Avg.



The legislation also included a provision to allow people to establish health savings accounts (HSAs), which combine a high-deductible catastrophic health insurance plan with a tax-preferred savings account for individuals under the age of 65. Although HSAs were legislated through a federal initiative, states play a role in their implementation.

Looking ahead to 2005 and beyond, states will continue to prepare for the Medicare drug benefit and to monitor how HSAs will play out in their markets. Many officials are also bracing themselves for the possibility of national Medicaid reform while continuing to explore how they can refine the program on their own. Although states are still a long way from realizing an economic recovery or implementing comprehensive reforms, 2004 saw many states finding alternate routes toward their coverage goals.

STATE BUDGETS AND COST-CONTAINMENT EFFORTS



After three years of falling revenues and budget-breaking expenditures, financial conditions appear to be improving in many states—albeit unevenly. Although states were still confronted with a combined budget shortfall of nearly \$40 billion for fiscal year (FY) 2005, that gap is half of what they faced a year ago.

Still, the consequences of the fiscal crisis that began in 2001 remained palpable last year, with persistent budget shortfalls, continuing unemployment, a slow recovery in tax revenues, and growing financial responsibilities continuing to challenge states. Policymakers remain cautious about their prospects for an economic recovery anytime soon.

Indeed, many states have exhausted one-time measures for closing budget gaps such as tapping cash reserves or rainy-day funds, as well as modest cuts to Medicaid and the State Children's Health Insurance Program (SCHIP) and revenue-enhancing options such as tax increases. As a result, they are turning increasingly to deeper spending cuts into their social programs, including reducing benefits, eligibility, or outreach for Medicaid and SCHIP.

On a positive note, two-thirds of states ended FY 2004 with modest budget surpluses. Although states still face much difficulty ahead, they appear at least to be moving in a positive direction.

Budget Gaps Shrink as Revenues Strengthen and Expenditure Cuts Deepen

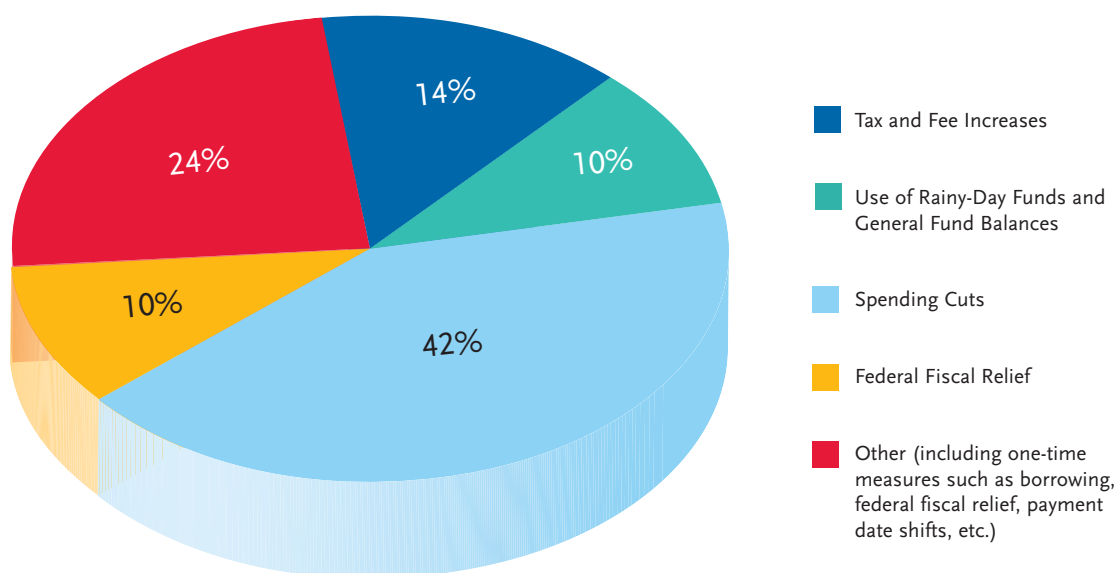
By law, most states must balance their budgets. The National Conference of State Legislatures (NCSL) estimates that, between FY 2002 and FY 2004, states had to contend with budget gaps that amounted to a staggering \$200 billion. States used a variety of measures to close this gap including tax and fee increases, rainy-day funds, spending cuts, and one-time measures such as borrowing and federal fiscal relief (see Figure 2 on p. 5).

One of the most significant indicators of fiscal improvement over the past year is that the disparities between state revenues and expenditures are starting to shrink. States faced an aggregate budget shortfall of \$80 billion when they enacted their FY 2004 budgets, according to the NCSL. In a sign of improving fiscal conditions, 32 states expected to end the fiscal year with a surplus.

The reason for the diminishing gaps appears to be a combination of increased revenues and spending cuts. For many states, revenues were buoyed by stronger-than-expected personal, sales, and corporate tax collections. In a recent study, the Nelson A. Rockefeller Institute of Government reports that state tax revenues grew during the last three quarters of FY 2004, which ended in June 2004 for the majority of states. This growth helped many states to meet or exceed revenue targets for FY 2004. The National Governors Association (NGA) and the National Association of State Budget Officers (NASBO) report that, for FY 2005, 24 states enacted tax and fee changes that resulted in a net increase in revenues of \$3.5 billion; these states raised an additional \$3.4 billion through measures that enhanced general fund revenues but did not affect taxpayer liability. In Connecticut, for example, officials proposed raising the per-pack tax on cigarettes from \$1.51 to \$2.05.

States also cut expenditures in FY 2004 to a greater degree than they had in FY 2003. The Rockefeller Institute study attributes the tendency to reduce spending to the fact that, by 2004, states may have already depleted one-time funding sources, such as cash reserves, rainy-day funds, and tobacco settlement earnings; many had exhausted revenue-enhancing options as well. Consequently, many states were left with little choice but to pursue spending cuts and other actions in order to balance their budgets. These actions ranged from across-the-board reductions to targeted cuts in social programs to layoffs, furloughs, and reduced local aid (see Figure 3 on p. 6).

Figure 2: Measures Used by States to Close Budget Gaps, Cumulative Totals FY 2002 – 2004



Source: McNichol, E. States' Heavy Reliance on Spending Cuts and One-Time Measures to Close Their Budget Gaps Leaves Programs at Risk, Center on Budget and Policy Priorities, July 29, 2004.

States Exercise Caution Amid Fiscal Uncertainty

Oregon is facing expenditure reductions after relying on revenue enhancements to close budget gaps in recent years. "The state has been slow to recover economically and is still experiencing high unemployment rates," says Jeanene Smith, M.D., M.P.H., of the Oregon Health Policy and Research Administration. And while revenues are increasing slowly, they are still insufficient to meet service demands. Furthermore, "the state has already used much of its rainy-day balances in the past to fill budget gaps," says Smith, leaving few options other than expenditure cuts.

The downturn in the nation's economy created budget problems that have plagued Massachusetts and other New England states for the past few years. As they prepare for the coming fiscal year, Massachusetts officials must contend with a budget gap in the range of \$600 million to \$1 billion. After several years of measures to control spending, the state faces the prospect of additional cuts to its Medicaid program.

While it is unclear how the projected budget deficit will affect the Medicaid program, "there are no easy cuts left," says Beth Waldman, the state's Medicaid director. Massachusetts officials have already frozen provider rates, reduced dental and vision benefits, and made cuts to the state program

that offers coverage to the long-term unemployed, which previously had no cap but is now limited to 36,000 enrollees. In addition, the state lowered the program's federal poverty level (FPL) ceiling from 133 percent to 100 percent FPL.

New Mexico's overall fiscal picture is brighter than that of other states. The state has substantial revenues from natural oil and gas resources. However, these revenues are not enough to cover growth in the Medicaid program, says Carolyn Ingram, New Mexico's Medicaid director. "While the overall budget is sound and the economic indicators are relatively good, our Medicaid program continues to grow," she says.

Medicaid Spending Continues to Outpace Other Categories

Medicaid remained a main driver behind states' budget problems in 2004. Nevertheless, cuts to the program were not a major element of most states' budget-balancing, according to a Rockefeller Institute of Government study of how 10 states treated Medicaid in their FY 2004 budgets. These states included Arizona, Colorado, Kansas, Michigan, New Jersey, Ohio, Oregon, Texas, West Virginia, and Wisconsin. The states made numerous Medicaid cuts, ranging from prescription drug cost controls and reduced provider payment rates to cutting benefits such as durable medical equipment, vision and dental benefits, and transportation.

While the rate of increase in Medicaid spending appears to have slowed temporarily, it continues to outpace growth in all other categories of state spending. For the first time ever, Medicaid surpassed elementary and secondary education as a component of total state spending.

These cuts were relatively modest, however, when compared to the size of either the total Medicaid program or the budget shortfall itself. On average, Medicaid cuts across these 10 states accounted for less than 7 percent of all measures to close budget gaps and only about 12 percent of expenditure cuts made by these states.

The Rockefeller Institute attributes the reluctance of states to cut Medicaid programs more deeply—at least during FY 2004—to financial incentives for states to minimize cuts to their Medicaid programs. State spending for Medicaid carries a federal match that is at least dollar-for-dollar in every state. Furthermore, as national and state economies improve, the federal match rate for some states has or will decrease. The reduction may be slight, but even a cut of a percentage or two represents a significant decrease in dollars. As a result, it may be more palatable for states to cut programs funded solely by state dollars.

While the rate of increase in Medicaid spending appears to have slowed temporarily, it continues to outpace growth in all other categories of state spending. For the first time ever, Medicaid surpassed elementary and secondary education as a component of total state spending. Driven by surges in enrollment, rising prescription drug costs, and increasing overall health care costs,

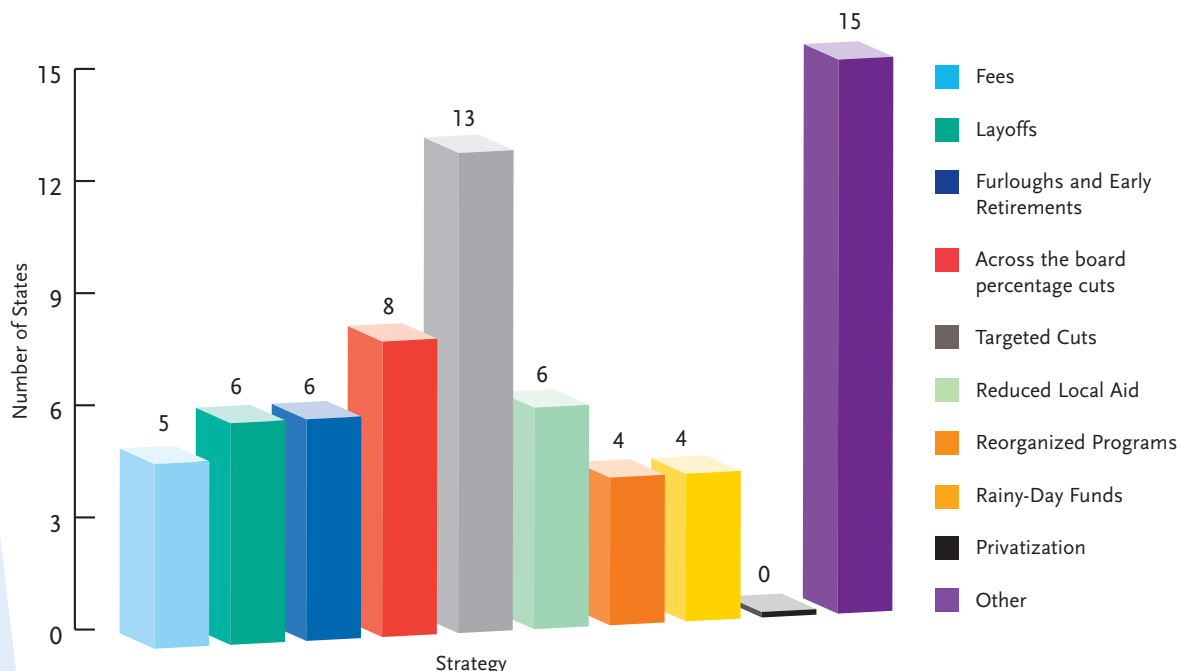
Medicaid consumed 21.9 percent of total state spending in FY 2004, according to NASBO. Elementary and secondary education accounted for 21.5 percent of all spending.

In spring 2004, 18 states anticipated a Medicaid shortfall for the fiscal year—a slight drop from FY 2003, when 23 states experienced program deficits. The NGA and NASBO estimate that states' combined Medicaid shortfalls in FY 2003 and 2004 was nearly \$7 billion, and that Medicaid costs will continue to outstrip revenue growth in the future. (For more about states' Medicaid cost-containment actions in 2004, see "The Changing Face of Medicaid" on p. 8, and "Medicaid Spending Drivers and State Strategies to Address Them" on p. 11.)

Bailout Provides Temporary Relief

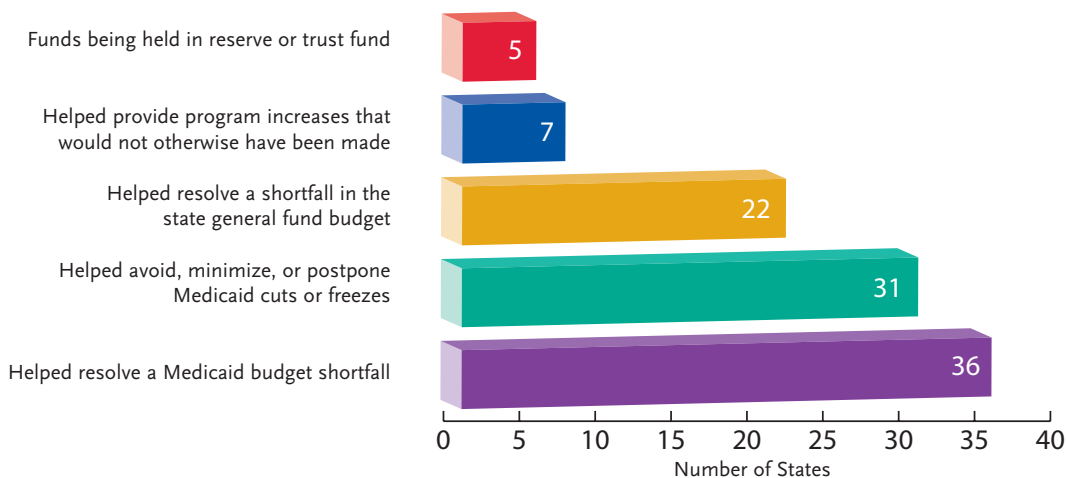
In FY 2004, budget pressures were eased by a one-time increase in federal Medicaid funds. The federal government's \$20-billion bailout helped states to manage their overall Medicaid budgets. Half of this fiscal relief was made available through a temporary increase in the federal Medicaid matching rate, and the balance was provided through grants aimed at Medicaid and other state programs. With \$10 billion slated for Medicaid programs, the temporary federal relief allowed many states to avoid or minimize Medicaid cost-containment initiatives.

Figure 3: State Strategies to Reduce Expenditures, FY 2004



Source: National Governors Association and National Association of State Budget Officers, *The Fiscal Survey of States*, April 2004, p. 29.

Figure 4: States Report Use of Temporary Federal Relief, FY 2004



Source: Smith, V. et al. The Continuing Medicaid Budget Challenge: State Medicaid Spending Growth and Cost Containment in Fiscal Years 2004 and 2005: Results from a 50-State Survey, *The Kaiser Commission on Medicaid and the Uninsured*, October 2004.

States put the funds toward Medicaid budget shortfalls, postponing and minimizing Medicaid cuts, and general fiscal relief (see Figure 4 above). The federal infusion also helped to hold the increase in states' share of Medicaid spending to 4.8 percent. For many states, however, federal relief fell short of the amount needed to close budget gaps and prevent aggressive cost-containment measures. Indeed, with no more federal relief in sight, the state share of Medicaid spending is expected to increase by 11.7 percent in FY 2005, according to the Kaiser Commission on Medicaid and the Uninsured.

For Minnesota, the temporary fiscal relief stabilized coverage for populations that were in place prior to 2003. With the expiration of federal relief in June 2004, officials in Minnesota, like those in other states, are anticipating heightened budgetary pressures for 2005. "The state will need to figure out a new solution this biennium because there are not enough resources to buy coverage for everyone we now have on our health care programs," says Christine Bronson, director for Minnesota's Medicaid program.

In New Mexico, the federal fiscal relief helped the state to patch budget holes in FY 2003 and 2004, but a drop in the state's Federal Medical Assistance Percentage rate in 2005 will mean an \$80 million loss in its FY 2006 and 2007 budgets.

Looking Ahead: One Step Forward

In a sign of growing economic health, states ended FY 2004 with higher year-end overall budget balances than in the previous year. These balances—which include both ending balances and budget stabilization funds—provide a critical buffer to states in the event of slowed

economic growth. After peaking in FY 2000 at \$48.8 billion, total year-end balances dropped significantly between FY 2001 and FY 2002. They have now leveled off, and appropriated FY 2005 balances are \$18.6 billion, or 3.4 percent of expenditures, according to the NGA and NASBO. These balances, however, remain well below the level considered fiscally prudent.

Indeed, despite indications that the fiscal crisis is ebbing, states have a long way to go before their revenues reach the same levels that they were before the economic downturn of 2001. Many are struggling once again to balance their budgets for FY 2005; 30 have identified potential gaps, with Alaska, California, Illinois, Louisiana, Nebraska, New Jersey, and New York facing especially large ones. Financial pressure on state Medicaid programs and uncertainty about their future is expected to be further compounded as states prepare to implement the new Medicare Part D prescription drug benefit. (For more about states' experiences with Medicare, see "How Federal Reforms Affected States," on p. 23.)

Moreover, a recent study from the Center on Budget and Policy Priorities suggests that it will be difficult to return to pre-recession budget levels because officials have already used most of the weapons in their arsenals to stanch the crisis over the past several years. States will need to experience robust economic growth in order to generate the revenues needed to fund normal program growth and restore recent cuts.



THE CHANGING FACE OF MEDICAID

In 2004, most states survived another bad budget year without having to make major Medicaid retrenchments. Increasingly, however, officials are coming to realize that the program cannot withstand the current rate of cost increases indefinitely.

Although Medicaid spending grew slower than private health insurance premiums (which rose by 11.2 percent) in Fiscal Year (FY) 2004, it rose faster than other state spending categories. Total Medicaid expenditures increased on average by 9.5 percent in FY 2004, similar to FY 2003's 9.3 percent growth rate. One million people were added to Medicaid and the State Children's Health Insurance Program (SCHIP) in 2004, accounting for more than one-third of Medicaid's cost growth.

Despite increasing Medicaid enrollment and costs, the number of uninsured continues to rise. This combination of surging costs, enrollment, and uninsured has created a "perfect storm" that is driving many Medicaid leaders to fundamentally rethink the way their programs are structured and operate.

In late 2004, the National Governors Association sent a letter to congressional leaders asking that they not address national Medicaid reform through the 2006 fiscal year budget reduction and reconciliation process. After efforts for national Medicaid reform stalled in 2003, many state officials have become wary that such broad reform efforts—in the form of block grants or deep federal cuts, for example—may be in the offing, and they fear that such reforms could have disastrous consequences. Others believe that making substantial changes through federal reforms is the only way the program will survive.

Meanwhile, over the past year state Medicaid leaders have increasingly talked about using their own waiver authority to make significant changes to the program, including altering benefits, imposing co-payments, or implementing new rules on pharmacy use. Some states are considering other, more significant changes to Medicaid, many of which are still in the conceptual phase.

Eligibility Reductions

Over the past decade, Medicaid and SCHIP have evolved to serve higher-income populations than they had before. According to The Kaiser Family Foundation, in five states, children in families with incomes of at least 300 percent of the federal poverty level (FPL)—which translates to \$47,010 for a family of three—are eligible for SCHIP. As of July 2004, 20 states have expanded coverage to parents of Medicaid or SCHIP kids beyond 100 percent FPL.

These expansions largely occurred during better budget times. Recently, however, some states have had to scale back enrollment (although Medicaid and SCHIP still serve a higher income group than they did a decade ago). Fifteen states made some type of eligibility cut in FY 2005 and 21 reduced eligibility in FY 2004.

Oregon

Oregon officials rolled back some of their programs' earlier expansions, eliminating their Medically Needy program altogether and charging premiums for even very low-income populations. These changes resulted in a 45 percent decline in enrollment under the Oregon Health Plan Standard program, which serves parents and childless adults up to approximately 100 percent FPL.

Tennessee

Officials in Tennessee proposed perhaps the most significant retrenchment from earlier state expansion efforts. On November 10, 2004, Governor Phil Bredesen (D) announced plans to eliminate the TennCare program—an expanded Medicaid managed care plan that was implemented in 1994. TennCare represented an ambitious expansion of Medicaid that extended coverage to so-called "uninsurable" individuals (those who find it difficult to obtain private insurance due to health status) and, for a brief period of time, the uninsured. Enrollment has been closed to all but the Medicaid population for more than three years.

Looking Ahead to SCHIP's Reauthorization

Congress enacted the State Children's Health Insurance Program (SCHIP) in 1998, authorizing \$48 billion over 10 years. Since then, the program has been credited with expanding coverage to nearly 5 million children in low-income working families. It has also spurred many state innovations in enrollment processes and outreach—many of which have had a spill-over effect into the Medicaid program. SCHIP's popularity in state capitols often crosses party lines, perhaps because it is a coverage program that is not viewed as an entitlement.

Despite its popularity, there are critical financing and policy issues surrounding SCHIP that are likely to be raised during its reauthorization. Congress failed to reallocate \$1.1 billion in unspent SCHIP funds in 2004, adding to the pressure to reauthorize SCHIP in 2005 well in advance of its 2008 expiration. However, in a separate redistribution, Secretary Thompson committed to redistribute \$660 million in unspent funds from 2002 to states that are likely to run out of Title XXI funding in 2005.

Currently, each state receives an annual allotment for SCHIP, which Congress has reallocated in past years because of the imbalance in state spending. The funding formula has proven flawed over the years, with 10 states spending twice their allotment and five spending less than half. Six states are projected to run out of SCHIP funds in FY 2005 and, by 2007, 18 states are likely to have inadequate funding. Reauthorization will have to address the adequacy of funding and allocation across states.

Another controversial financing issue has been some states' use of SCHIP funds to serve adult populations under a waiver. Some congressional leaders have criticized the Centers for Medicare and Medicaid Services for approving such waivers, claiming that the intent of SCHIP is to serve children. According to a 2004 report of the Government Accountability Office, SCHIP's statutory objective to expand health coverage to low-income children is inconsistent with waivers intended to spend SCHIP funds on childless adults. In addition,

because unspent SCHIP funds can be redistributed, states' coverage of parents and childless adults decreases the funding available in future years for redistribution to states with unmet SCHIP needs, according to the report.

Reauthorization may raise policy issues in the SCHIP program. For example, some officials and advocates have questioned the equity of provisions to prevent crowd-out (the substitution of public coverage for private), which they say penalize families who had paid for private health insurance by requiring them to be uninsured for a specific period of time prior to enrolling in SCHIP.

State officials have also found it challenging to implement an employer-sponsored insurance (ESI) option under SCHIP. The Health Insurance Flexibility and Accountability (HIFA) demonstrations address many of these concerns. (For more on HIFA, see p. 16.) Still, only a few states have succeeded in getting a premium-assistance program of any size off the ground. Rhode Island and Illinois are innovators in this area. Both states enroll parents of SCHIP-eligible children in Medicaid; this has made it easier for them to demonstrate that premium assistance is more cost-effective than public coverage alone, as federal regulations require them to do.

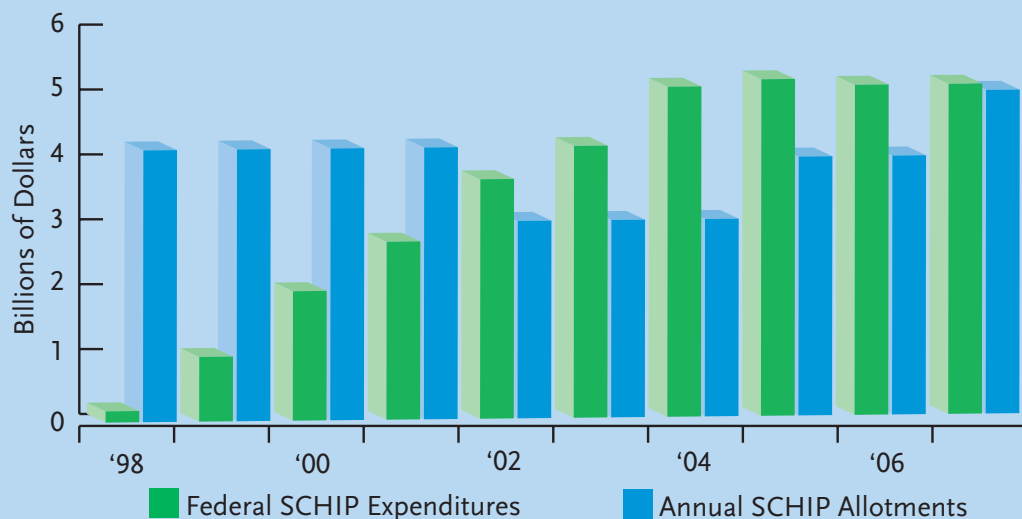
Officials in Rhode Island are striving to work around the current employer-sponsored insurance options in their state. They enroll children and parents when it is cost-effective and provide "wrap-around" Medicaid services to supplement employers' benefits when they are less comprehensive than Medicaid's. Conversely, Illinois' program allows families to make an informed choice between ESI and Medicaid rather than wrapping around coverage.

Enrollment in ESI in these states is still low relative to Medicaid, but officials believe that their programs save money. Rhode Island's analysis demonstrates that \$1 million is saved for every 1,000 full-year enrollees in Rite Share, the state's premium assistance program. Nationally, ESI enrollment is still less than 1 percent of the total Medicaid population.

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Despite its popularity, there are critical financing and policy issues surrounding SCHIP that are likely to be raised during its reauthorization.

Figure 5: Expenditures of Federal SCHIP Funds Versus Federal SCHIP Allotments



Source: Center on Budget and Policy Priorities, www.cbpp.org.

Many states have implemented changes in their benefit package as part of their cost-containment efforts. According to The Kaiser Family Foundation, nine states reduced their benefit package in FY 2005, while almost 20 reduced benefits in FY 2003 and FY 2004.

Bredesen's announcement came after advocates challenged an earlier proposal to sharply reduce TennCare benefits to control cost growth; his proposed changes ran afoul of existing court mandates that have been won over the years by TennCare patient advocates. Bredesen was not able to convince advocates to back away from those mandates.

"TennCare was, and is, a wonderful dream," said the governor in announcing the end to the program. "It appears that the dream is over." According to Bredesen, any loss in coverage would not occur immediately. The state plans to begin notifying individuals in March 2005. As a result, coverage will be eliminated for 323,000 Tennessee residents.

The TennCare expansion had been financed largely on the assumption that the state would save money by moving Medicaid to a managed care model. Over the years, however, the program has often struggled financially and experienced many tumultuous changes such as plan withdrawals and insolvencies, freezes in new enrollment, and provider payment issues.

Mississippi

During FY 2005, Mississippi officials passed one of the deepest cuts in Medicaid eligibility to date, eliminating Medicaid coverage for approximately 65,000 elderly and disabled adults between 100 and 133 percent FPL. Many of these individuals are also eligible for Medicare, but rely on Medicaid for critical "wrap-around" services, such as prescription drug coverage and nursing home services.

To minimize the impact of the proposed coverage changes, state officials requested a federal waiver to retain 17,000 of the 65,000 individuals originally slated to be cut from the program. The state received the waiver in September 2004. Those who would be preserved through the waiver are a targeted group of vulnerable citizens, including individuals who are not eligible for Medicare and dual eligibles who rely on anti-rejection drugs after organ transplant, require kidney dialysis, or receive anti-psychotic drugs.

Even with the waiver, 48,000 dual eligibles would lose Medicaid wrap-around coverage. A coalition of advocacy groups filed a lawsuit in September 2004 claiming that the 48,000 individuals were not properly notified about the loss of coverage. Officials negotiated a settle-

ment allowing them to remain covered until March 1, 2005. Following this deadline, the state plans to move forward with the eligibility changes.

Changing Benefit Packages

Many states have implemented changes in their benefit package as part of their cost-containment efforts. According to The Kaiser Family Foundation, nine states reduced their benefit package in FY 2005, while almost 20 reduced benefits in FY 2003 and FY 2004.

Colorado

Officials in Colorado are developing a waiver to coordinate the purchasing for Medicaid, Child Health Plus (the state's SCHIP program), and other indigent care programs. The state already has a lean Medicaid benefit package, and one of the waiver principles is to leave eligibility for Medicaid and Child Health Plus intact.

The proposal would streamline the delivery of care to enrollees into one system through which most Medicaid and Child Health Plus enrollees would receive a "core" benefits package that contains fewer benefits than traditional Medicaid but is still anticipated to meet their needs.

Children with special health care needs would receive more comprehensive "core plus" services through a wrap-around benefit package. Core plus benefits may include intensive mental health services, extended physical or speech therapy, and some durable medical equipment. Contributing to the decision to shift to a new streamlined delivery system was the loss of several HMOs in the Medicaid program; officials also wanted to enhance the state's purchasing power and promote continuity of care and coverage for Medicaid and SCHIP. In addition, Colorado officials are looking at strategies to incorporate a premium assistance model with the new streamlined program.

New Mexico

In New Mexico, officials implemented new cost-sharing requirements for many Medicaid benefits and re-evaluated the benefits planned for the state's not-yet-implemented waiver expansion—which proposes to extend coverage to low-income adults. Based on concerns from the advocacy community, the planned expansion will offer a package with more benefits than originally proposed, but still fewer than are available to current Medicaid beneficiaries.

Medicaid Spending Drivers and State Strategies to Address Them

Medicaid and the State Children's Health Insurance Program are the largest health care purchasers in the country. They are vulnerable to the same factors that are driving up health care spending in the private sector: surging demand for costly pharmaceuticals, increasing inpatient and outpatient utilization, and the availability of costly new technology. In addition, increasing Medicaid enrollment and the rising cost of long-term care have been key drivers of Medicaid spending growth over the past few years.

Enrollment

Medicaid enrollment grew substantially over the past few years as more families and children fell into poverty or lost their health insurance during the recent economic downturn. In fiscal year (FY) 2004 alone, enrollment increased by 5.2 percent, and it will continue to grow at a strong but slightly slower pace of 4.7 percent in FY 2005, according to the Kaiser Commission on Medicaid and the Uninsured. In the Commission's 50-state survey, state Medicaid officials listed enrollment growth as the No. 1 reason for increased Medicaid spending in FY 2004 and FY 2005.

Prescription Drugs

Prescription drug costs continue to be a major factor contributing to Medicaid budget shortfalls. Between 1997 and 2000, Medicaid prescription drug spending grew at an average annual rate of 18.1 percent and accounted for almost 20 percent of the increase in Medicaid spending during this period. Virtually all state Medicaid programs have implemented some type of prescription drug cost-containment initiative over the past few years.

The most common strategies include increased use of prior authorization or preferred drug lists (PDLs). The former typically requires providers to get approval from the state to prescribe certain medications when equally effective, less expensive drugs are available, and the latter is a list of drugs determined to be both low-cost and clinically effective; drugs not on the PDL may be subject to prior authorization. Both approaches are intended to encourage the use of cost-effective prescription medications for which states have negotiated supplemental rebates.

In 2004, states were given the added challenge of sorting through the implications of the Medicare Modernization Act on their strategies to reduce pharmacy costs. According to the National Governors Association, pharmacy spending on dual eligibles—those eligible for both Medicare and Medicaid—accounted for 48.5 percent of total Medicaid pharmacy spending in 2002. Once the Part D benefit is implemented in January 2006, the drug expenditures for the dual eligibles will no longer be managed by states. This loss in volume in drug purchasing will lessen states' ability to use their purchasing power to leverage cost savings.

Long-Term Care

Long-term care (LTC) services account for almost one-third of all state Medicaid spending. As cost pressures mount, more states are pursuing strategies to help reduce LTC expenditures. Many are using flexibility within the Medicaid program to provide LTC services in less expensive settings, including home- and community-based programs. In some cases, however, these states are finding that demand for home- and community-based services is increasing without necessarily resulting in lowered nursing home expenditures, and many have limited enrollment in these programs.

To date, most states have relied on traditional cost-containment strategies such as reducing provider reimbursement or restricting eligibility to contain LTC costs. According to a recent Kaiser Commission Survey, the number of states focusing on LTC programs to control costs has increased from 10 states in FY 2003 to 17 in FY 2005. Some states are considering a managed care model for long-term care services.

Disease Management

Disease management (DM) continues to be a part of many state officials' cost-containment solution. According to a recent Kaiser Family Foundation survey of Medicaid directors, 28 states reported adopting DM strategies in FY 2005, up from 18 in FY 2004. DM programs are designed to reduce costs by improving health outcomes among those with chronic conditions such as asthma, congestive heart failure, HIV/AIDS, and hypertension. Medicaid enrolls a disproportionate number of adults with chronic conditions, and they in turn account for the majority of spending in the program.

Although preliminary data suggest that DM programs contribute to improved quality of care, a recent analysis by the Congressional Budget Office found there was insufficient evidence to conclude that DM reduces health spending. Moreover, evaluating actual cost savings is a challenge because it is difficult to identify adequate comparison populations and to tease out DM's contribution to changes in health care spending relative to other factors that may influence costs.

Still, state Medicaid leaders remain hopeful that savings can be achieved by adopting DM strategies and expanding those already in existence. The need to achieve immediate cost savings is driving some states to contract out DM functions to vendors who can set up a program quickly and may guarantee a level of savings.

California

Citing the 60 percent increase in state spending under California's Medicaid program—called Medi-Cal—over the past five years, Governor Schwarzenegger's FY 2004–05 budget calls for a broad redesign of the program.

The Medi-Cal Redesign Initiatives include:

- ◆ Expanding managed care programs to families, children, seniors, and persons with disabilities.
- ◆ Seeking a new five-year hospital financing waiver that will allow the state to continue contracts with selected hospitals serving low-income and vulnerable populations.
- ◆ Modifying the Medi-Cal benefit package by placing an annual limit of \$1,000 on dental services provided to adults. This limit will not apply to federally mandated dental services provided by a physician, emergency dental services, and hospital costs associated with dental treatment.
- ◆ Establishing new beneficiary cost sharing based on income levels—families and children in households with incomes above 100 percent FPL and seniors and persons with disabilities with incomes above the Supplemental Security Income/State Supplemental Payment level. Premiums will be \$4 per month for each child under the age of 21 and \$10 per month for adults, with a maximum of \$27 per month per family.
- ◆ Improving eligibility processing for Medi-Cal applications for children.

State officials need to receive CMS approval to implement the program; this means that they will have to operate it under a budget neutrality cap—a fact that has some stakeholders concerned that the redesign

may shift to the state costs for higher-than-expected enrollment or other health care costs. The governor's original timeframe for seeking waiver approval was delayed. The restructuring proposal was released as part of the governor's budget in January 2005.

New Hampshire

In September 2004, New Hampshire officials drafted a proposal that would fundamentally change the entitlement nature of the Medicaid program for several groups of people. The proposal would move eligible individuals with incomes greater than 133 percent FPL into health service accounts, which are similar to the health savings accounts (personal accounts that are coupled with catastrophic coverage; for more information, see "How Federal Reforms Affected States" p. 23).

The health service account will provide higher-income Medicaid enrollees with an individual budget (i.e., a set dollar amount to enrolled individuals through a health service account) to pay for their health care; if they don't use all of these funds and meet certain preventive health goals, a portion of the unspent funds may be returned to the Medicaid enrollee. Officials hope that, if Medicaid enrollees are given an individual budget, they may make more cost-effective choices that reduce unneeded care.

The proposal would use a catastrophic pool to manage high-cost individuals, encourage greater use of community-based services for the elderly and individuals with disabilities, and pay for behavioral health services and developmental disabilities services under an individual budget. The state would outsource several activities to manage care and create a single point of entry for individuals with behavioral health care needs, developmental disabilities, or elderly individuals in need of long-term care.

STATE APPROACHES TO EXPANDING COVERAGE

In 2004, states were once again forced to find inventive and practical ways to address their uninsured with tight resources. However, as state finances showed the first signs of improvement in years, officials in some states looked beyond stop-gap measures toward more comprehensive approaches to the issue.

A few states have been using the more “traditional” strategy of expanding Medicaid and the State Children’s Health Insurance Program (SCHIP) to new populations. Others continued to reach out to the private sector to build partnerships, with many beginning to look for new ways to collaborate. Although there were few new waiver approvals last year, several states are currently working on waiver applications or considering that route. Finally, residents in several states voted on ballot initiatives that could have a significant impact on health coverage.

Partnering with the Private Sector

Last year, there continued to be emphasis on reaching out to the private sector. The idea of building public-private partnerships remains a viable mechanism for expanding coverage in the states’ view—particularly as a way to ease the financial burden on states. However, states’ discussions about these types of partnerships are no longer solely focused on premium assistance programs. In some states, the premium assistance strategy has been set aside until existing state programs are able to demonstrate that they can overcome substantial enrollment challenges. Some state officials have recognized that premium assistance may not be a viable option for addressing large numbers of working uninsured. In 2004, a few states made strides in working with the private sector in other ways.

West Virginia

In mid-March, West Virginia passed legislation intended to enable more small businesses to provide coverage to their employees. The State Coverage Initiatives (SCI) program helped to make the proposed expansion possible by providing the state with a \$1.36 million demonstration grant in 2003; the grant was intended to support

the design and implementation of a new coverage program.

The new law creates a public/private partnership between the West Virginia Public Employees Insurance Agency (PEIA) and insurance companies. The private carriers will be given access to PEIA’s reimbursement rates, enabling them to sell coverage that is more affordable than they have been able to sell previously. In fact, the state expects the new small business coverage cost to be 20–25 percent below the usual market rate—which will ultimately expand the pool of insured working West Virginians.

During the fall, the West Virginia Health Care Authority reached out to health care providers and insurance carriers to solicit participation in the program. “Passing the legislation was the easy part,” says Gerry Rouche, executive assistant to the director of PEIA. “Marketplace success will be the true test.”

The new coverage plan will be open to small businesses with 2 to 50 employees who have had no coverage for 12 consecutive months. Employers will be required to pay a minimum of 50 percent of the premium cost for employee-only coverage, and 75 percent of eligible employees must participate. Participating carriers must demonstrate a minimum anticipated medical loss ratio of 77 percent to be eligible for a rate increase after the first year of the plan (the current requirement is 73 percent). As of December 2004, one carrier has filed with the state to offer the new product, which was available January 1, 2005.

Hawaii

The Hawaii Uninsured Project (HUP) was developed with support from both a Health Resources and Services Administration’s (HRSA) State Planning Grant Program and an SCI demonstration grant. Under the project, several working groups

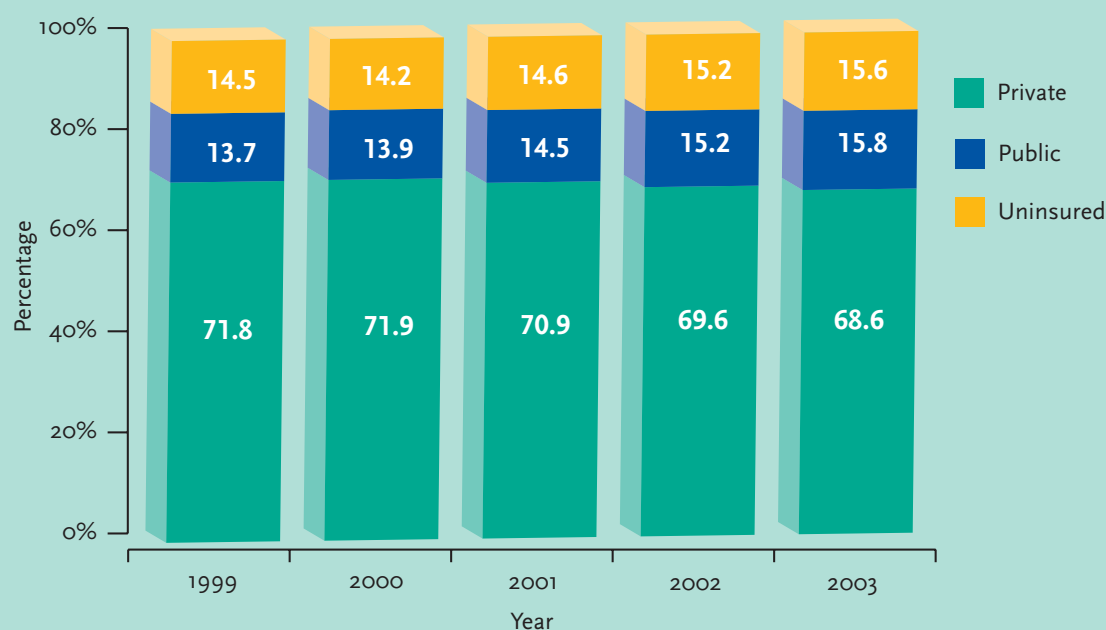


Recent Data on the Uninsured in America

According to data released in August from the U.S. Census Bureau's Current Population Survey (CPS), 45 million Americans did not have health coverage in 2003. These data document that the number of uninsured has risen for the third straight year. The newest CPS estimates were published in the report, *Income, Poverty and Health Insurance Coverage in the United States: 2003*, which also found that:

- ◆ The number of people without health insurance rose from 15.2 percent of the population in 2002 to 15.6 percent in 2003—an increase of 1.4 million people.
- ◆ Uninsurance rates among children remained stable from 2002 to 2003.
- ◆ There was a drop in the rate of employer-based insurance from 61.3 percent in 2002 to 60.4 percent in 2003.
- ◆ The proportion of people covered by government health insurance programs, including Medicare, Medicaid, and SCHIP, increased from 25.7 percent in 2002 to 26.6 percent in 2003.

Figure 6: Sources of Health Insurance Coverage, Individuals under 65



Source: CPS March 2003 Supplements 1997-2002. 2003 Data from Income, Poverty, and Health Insurance Coverage in the United States: 2003, CPS, August 2004.

met over the last year to develop policy options to insure uncovered workers and low-income children and adults.

Hawaii is the only state with an employer mandate—the Prepaid Health Care Act (PHCA). Under this Act, all employers in the state must offer health insurance to their full-time workers (those who are employed more than 20 hours per week for four consecutive weeks). Employees' contribution for the coverage cannot exceed 1.5 percent of their wages; that figure was in line with the national average when the law was created in 1974, but is currently much lower than that paid by workers in other states.

As a result of the PHCA, Hawaii has one of the highest percentages of employers offering health insurance in the nation (89.6 percent, compared to a national rate of 57.2 percent) and of small firms offering coverage (86.1 percent in the state vs. 44.5 percent nationally). Still, there are gaps in coverage. Hawaii's proportion of part-time workers is greater than the national rate, and self-employed workers and children (who are also not covered by the PHCA) are more likely to be uninsured as well. In addition, according to research from the University of Hawaii, some individuals who should be covered under the PHCA report being uninsured—which raises questions for the state about enforcement of, and education about, the law.

Among the strategies presented in 2004 to the HUP leadership group was an individual mandate for the working uninsured. Through a public/private collaboration, an affordable insurance plan would be developed that would be required for all exempt workers not covered by the PHCA. “We are working with key stakeholders to discuss how such a proposal would work,” says Laurel Johnston, executive director of the project. “We are exploring what is affordable for these exempt low-income workers.”

Medicaid and SCHIP Expansions

In light of continuing fiscal challenges, most states were unable to pursue Medicaid and SCHIP expansions, other than making some minor eligibility changes. Only Illinois was able to continue its commitment to expand coverage in 2004.

Illinois

Some of the most positive coverage news in 2004 came out of Illinois. Like most states, Illinois has faced tough fiscal times. However, despite the state’s historic budget crisis, it increased coverage among working parents through FamilyCare—its SCHIP premium-assistance program—between December 2002 and December 2003. The expansion was part of a HIFA waiver that was approved in September 2002.

Under this waiver, Illinois also expanded the eligibility level for KidCare, the state’s SCHIP program, from 185 to 200 percent of the federal poverty level (FPL). In addition, state officials have raised eligibility for FamilyCare in increments from 49 to 133 percent FPL—which is expected to add 56,000 parents to the FamilyCare rolls. “I’m proud of the progress we have made in providing health care for children and families,” said Governor Rod Blagojevich (D) in an August 2004 press conference.

Comprehensive Reform Plans

More and more, officials have begun to develop health care strategies that address issues beyond coverage alone. For example, governors from Kansas and Massachusetts both presented comprehensive proposals late in November 2004. Maine’s Dirigo remains one of the most ambitious health care proposals that states have seen in several years. By taking a systematic approach that targets cost, quality, and access, Dirigo created a buzz in the coverage world in 2004.

Kansas

Kansas Governor Kathleen Sebelius (D) announced that the state will undertake a \$50-million HealthyKansas initiative. Under the proposed multi-pronged effort, the state will: 1) expand health insurance to an additional 40,000 children and 30,000 working parents; 2) assess how to control health care costs through risk sharing—particularly for small businesses; 3) improve the availability of generic drugs for low-income individuals; and 4) increase awareness of obesity and other preventable chronic conditions.

In order to push these system-wide reforms, improve efficiency, and concentrate the state’s purchasing power, officials will create two entities to push this initiative forward: the Kansas Health Care Authority, a new division within the state that will hold all of Kansas’s health care programs, and the Kansas Health Care Cost Containment Commission, a group that will identify and reduce unnecessary administrative costs in the system.

Massachusetts

Governor Mitt Romney (R) of Massachusetts also announced his “Commonwealth Care” proposal in November. The strategy includes four market-based strategies, including to: 1) eliminate insurance mandates to entice small businesses to offer insurance and penalize firms that fail to offer coverage; 2) reach out to Medicaid-eligible but unenrolled citizens; 3) replace the uncompensated care pool with a managed treatment system called Safety Net Care; and 4) expand the duration of coverage the state offers to unemployed workers.

Maine

Under Dirigo, which translates to “I lead” in Latin, Maine will ensure access to coverage to as many as 180,000 state residents, specifically small-business employees, the self-employed, and individuals. Dirigo is a comprehensive health care program designed to expand coverage to all Mainers by 2009, to bring down the cost growth of health care in the state, and to improve the quality of care provided to its citizens.

Under Dirigo, the state expanded MaineCare, the state’s Medicaid and SCHIP program, under its existing waiver authority. Parents with incomes up to 200 percent FPL and childless adults earning less than 125 percent FPL became eligible.

A second component of Dirigo is a public/private health plan called DirigoChoice, which is intended for businesses of 2 to 50 employees, the self-employed, and unemployed or part-time workers. Dirigo provides sliding-scale premium discounts according to a sliding-fee schedule to enrolled individuals and families based on their ability to pay. Employers who offer this product to their employees and pay at least 60 percent of its cost benefit from lower rates as a result of greater risk pooling.

In mid-2004, state officials solicited bids from insurers and, after negotiations, contracted with Anthem Blue Cross and Blue Shield to underwrite DirigoChoice. In early October 2004, Maine employers began to enroll in DirigoChoice. After negotiations, state officials contracted with Anthem Blue Cross and Blue Shield of Maine. Coverage started January 1, 2005. The first-year plan is to enroll up to 31,000 Maine residents through their employers, and 4,500 self-employed or unemployed individuals.

As of January 1, 2005, DirigoChoice has enrolled and is providing benefits for 133 small businesses and 612 sole proprietors for a total of 1,800 members. The Dirigo Health Agency is seeing activity at a similar rate for the February 1 coverage effective date. Officials expect a significant enrollment response, as many people were waiting for this product to become available. “We’re working seven days a week to make sure this program moves forward as planned,” says Ellen Schreiber, deputy director of the governor’s office of health policy and finance. “We are very sensitive to the ramifications of a delayed start and are doing everything in our power to make sure that doesn’t happen.”

Maine officials have taken a number of approaches to financing the expansion, including using \$53 million in state funds, and more in federal match funds by expanding its Medicaid program. They have also urged hospitals, physicians, and carriers to limit voluntarily their net revenue or charge increases in excess of 3 percent annually.

After the first year of DirigoChoice, Maine officials plan to charge insurance companies an annual assessment not to exceed 4 percent of their premiums. This will be levied only if cost savings are achieved in the health care system through reductions of bad debt and charity care and other cost-containment provisions. This “savings offset pay-

ment” is the most interesting—and perhaps most controversial—component of the funding plan.

State officials reason that the fee represents just a portion of the annual cost of charity care, which is built into health care prices and insurance premiums. Moreover, under Dirigo, a larger segment of the population will be insured, thus decreasing the need for charity care and ensuring access to early and preventive care. Insurers are prohibited from passing the savings offset payment forward into insurance prices.

“All states are watching Dirigo to see if this might be a new model for expanding health insurance coverage, especially among low-income workers who cannot pay high premiums or cost-sharing,” says Deborah Chollet, a senior fellow at Mathematica Policy Research, who has worked extensively with Maine officials to estimate program enrollment and cost.

Waivers

Last year was not a particularly active year in terms of waivers that were submitted and/or approved. Since the introduction of the Health Insurance Flexibility and Accountability (HIFA) waivers in 2001, the waiver strategy has changed the coverage landscape for states. These waivers have been a tool for states to use greater flexibility to change benefits, eligibility, and cost-sharing for new and current beneficiaries in their public programs. The U.S. Department of Health and Human Services has approved 10 waivers since HIFA was introduced.

After an initial surge of HIFA submissions over the previous years, states were not particularly active in proposing or implementing the waivers in 2004. Still, states continue to express an interest in HIFA, and it remains the preferred section 1115 waiver approach of the Centers for Medicare and Medicaid Services (CMS)—although the initiative is not without its critics. A 2002 report from the General Accounting Office (GAO—now called the Government Accountability Office) criticized CMS’s approval of state proposals to use SCHIP funds for childless adults as inconsistent with the program’s statutory objective of expanding coverage to children. This issue will likely be revisited as SCHIP approaches reauthorization. (For more about SCHIP reauthorization, see “Looking Ahead to SCHIP’s Reauthorization” on p. 9.)

Figure 7: Health Insurance Flexibility and Accountability (HIFA) Demonstrations

State	Approval Date	Expansion Population	Precedents/Additional Design Features
Arizona	12/01	<ul style="list-style-type: none"> ◆ Childless adults with income up to 100% FPL ◆ Parents of Medicaid and SCHIP children with income between 100% and 200% FPL 	<ul style="list-style-type: none"> ◆ SCHIP funding for childless adults ◆ Refinancing at enhanced Federal Medical Assistance Percentages of previous section 1115 demonstration population
California	1/02 (not yet implemented)	<ul style="list-style-type: none"> ◆ Parents/legal guardians of SCHIP children with income up to 200% FPL 	N/A
New Mexico	8/02 (not yet implemented)	<ul style="list-style-type: none"> ◆ Childless adults and parents of Medicaid and SCHIP children with income up to 200% FPL 	<ul style="list-style-type: none"> ◆ Design of ESI component; no direct state coverage
Colorado	9/02	<ul style="list-style-type: none"> ◆ Pregnant women with income between 133% and 185% FPL 	N/A
Illinois	9/02	<ul style="list-style-type: none"> ◆ Parents of Medicaid and SCHIP children with income up to 185% FPL (beginning with 54% FPL with intention of incremental phase-in) 	<ul style="list-style-type: none"> ◆ Informed choice between ESI and direct coverage ◆ Federalization of high-risk pool ◆ Federalization of hemophilia program
Maine	9/02	<ul style="list-style-type: none"> ◆ Childless adults with income up to 100% FPL 	<ul style="list-style-type: none"> ◆ Use of unspent disproportionate share hospital payments
Oregon	10/02 (amendment to existing demonstration)	<ul style="list-style-type: none"> ◆ Individuals with income up to 185% FPL, some of whom were previously covered in a state-funded premium-assistance program 	<ul style="list-style-type: none"> ◆ Denial of service for refusal to pay cost sharing
New Jersey	1/03	<ul style="list-style-type: none"> ◆ Parents with income between 100% and 133% FPL 	<ul style="list-style-type: none"> ◆ Use of Medicaid eligibility state plan amendment to create “expansion”
Michigan	1/04	<ul style="list-style-type: none"> ◆ Uninsured childless adults at or below 35% FPL 	
Idaho	11/04	<ul style="list-style-type: none"> ◆ Children in families with income up to 185% FPL in Medicaid ◆ Children in families with income between 150% to 185% FPL in separate SCHIP program ◆ Small business employees with annual incomes below 185% FPL—program capped at 1,000 adults 	

HRSA State Planning Grants—A Strong and Evolving Coverage Resource for States

Through a series of one-year grants of approximately \$1 million, a majority of states have been able to study their demographics and health insurance trends in order to develop coverage options.

Over the past six years, the Health Resources and Services Administration's (HRSA) State Planning Grant (SPG) program has been a tremendous coverage resource to states and U.S. territories looking to maintain their progress on the uninsured in the wake of tight economies. Through a series of one-year grants of approximately \$1 million, a majority of states have been able to study their demographics and health insurance trends in order to develop coverage options. For Fiscal Year (FY) 2004, HRSA awarded more than \$13 million through nine new state planning grants, 17 continuation planning grants, and nine "pilot project planning" grants—which are new this year.

The most recent HRSA SPGs were awarded to American Samoa, Guam, Kentucky, Louisiana, Michigan, North Carolina, Pennsylvania, Puerto Rico, and Tennessee. All of these states and territories plan to use their grants to collect data on their uninsured through state surveys, focus groups, and key informant interviews. Many states plan to produce studies, establish advisory groups or steering committees to aid policymaking, and hold town hall meetings and community forums.

This year, for the first time, the U.S. Department of Health and Human Services has expanded the SPG program to include a new type of award called pilot project planning grants. These grants provided funds to states that have already developed policy options through SPG funds to enable them to:

- ◆ Plan for the implementation of a specific policy option(s) on which consensus has been reached;
- ◆ Test a particular option in one or more areas and/or for a specific population in the state or territory; and
- ◆ Implement a plan that will cover a significant portion of the uninsured.

The FY 2004 recipients of these new pilot grants include Connecticut, Delaware, Georgia, Illinois, Indiana, Kansas, Oklahoma, the U.S. Virgin Islands, and West Virginia. HHS anticipates funding up to 18 pilot grants in FY 2005.

Because all the pilot grant recipients had already studied their uninsured through their State Planning Grants, the awardees went into the process prepared to target the segments of their populations that would best be served by a pilot. Through their research, most states have found that the majority of the uninsured are low-income workers who are employed by small businesses that do not offer coverage. Consequently, many of the pilot plans involve creative ways to provide health insurance to this population and encourage small-business owners to offer coverage options to their workers.

The nine new pilot project grantees intend to use their grant funds in the following ways:

- ◆ The **Connecticut** pilot grant team plans to provide premium assistance targeted to low-income workers in firms that already offer coverage, and to implement a small employer health insurance subsidy pilot targeted to small firms that do not offer coverage.
- ◆ The **Delaware** pilot grant team plans to strengthen the safety net with their grant funds by reaching out to those who are eligible but not enrolled in public programs and further broaden coverage through an employer-focused approach.
- ◆ Recognizing geographic differences in coverage trends, **Georgia's** pilot grant team will implement separate pilots in four communities. They are exploring several options, but one of the communities will pilot a "three-share" program—in which employers, workers, and the local government share in the cost of health care—and another will partner with commercial insurers to reduce costs to a target population.
- ◆ In **Indiana**, the project team intends to create a small business pool coupled with an employer/employee buy-in and premium-assistance program.
- ◆ Officials in **Illinois** are looking into contracting with an actuary to develop a three-share program in two counties.
- ◆ The **Kansas** pilot grant team will model the combined effect of reinsurance (in which the state takes on a portion of insurers' high-cost claims), tax credits aimed at small business, and low-wage worker premium subsidies on health insurance price and take-up.
- ◆ Officials in **Oklahoma** are considering creating a small-group purchasing pool with their grant funds.
- ◆ The team from the **U.S. Virgin Islands** plans to use its pilot grant award to develop an association health plan as a purchasing collaborative. In the process, they will develop a comprehensive Preferred Provider Organization (PPO) network, implement effective disease management in the PPO, increase Medicaid enrollment, and continue to analyze the costs of uncompensated care.
- ◆ **West Virginia's** project team will use their grant funds to develop options to offer affordable health insurance to the pre-Medicare population (aged 50 to 64), specifically those who have lost or are at risk of losing their retiree benefits.

For more information on the HRSA state planning grant program, visit: www.hrsa.gov/osp/stateplanning/ and www.statecoverage.net/hrsa.htm.

Michigan

Michigan is one of two states that received approval for a HIFA waiver and implemented the proposal in 2004. Approved in January 2004, the waiver allows the expansion of coverage to 62,000 uninsured childless adults at or below 135 percent FPL. Funded from the state's unspent SCHIP allotment, the Adults Benefits Waiver program was designed to provide new beneficiaries with a benefits package that is less broad than Michigan's standard Medicaid or SCHIP coverage. In order to meet the HIFA requirement to coordinate with private insurance, officials are also offering to beneficiaries with access to employer-sponsored insurance a voucher that is equal in value to the state's cost of providing service. Enrollment in the employer-sponsored plan is in lieu of receiving benefits through the state plan.

Idaho

CMS approved Idaho's HIFA waiver application in November 2004. The waiver program, called the Idaho Access Card, is intended to increase access to affordable private health insurance. To accomplish this, the state will offer premium assistance to cover children in families whose gross annual income is above mandatory Medicaid levels but below 185 percent FPL.

Idaho officials also submitted a Title XXI state plan amendment to create a separate SCHIP program, CHIP-B, in conjunction with its HIFA waiver proposal; the program was approved in June 2004 and implemented in July. It will be available to children whose parents earn incomes ranging from 150 to 185 percent FPL.

Under the new Access Card program, parents of children who qualify for SCHIP-funded coverage will have a choice between having the children covered through a state-sponsored direct benefit program or a premium-assistance program; the latter allows parents to add their eligible dependents to their existing employer-based insurance plan (or to an individual insurance policy) and have the state pay up to \$100 toward the amount of the dependent's premium.

When CMS approves a recently submitted HIFA waiver amendment, the Access Card program will also offer premium assistance to adults whose gross annual income is under 185 percent FPL and who are employed by an Idaho small business, or are the spouse of an employee. The program will be capped at 1,000 adults and is slated to begin July 1, 2005.

New Mexico

New Mexico is among the small number of states that has a HIFA waiver from several years ago that has not yet been implemented. In August 2002, CMS approved the waiver, which outlined the implementation of a premium-assistance program that will combine federal, state, and employer dollars to provide health insurance to adults with incomes up to 200 percent FPL.

Unlike traditional premium assistance programs, New Mexico's program creates a new insurance product for small employers. The state designed a benefit package that is more in line with commercial insurance than Medicaid benefits. Small employers that have not voluntarily dropped insurance may enroll their low-income workers in this new program.

Officials estimate that the new insurance product will cost approximately \$300 per month; the employer is expected to pay \$75, the employee \$25, and Medicaid will pay the remaining \$200 (of which \$35 is the state's share). Low-income adults whose employers are not willing to participate in the program may still enroll, but must pay the employer and employee contribution. State officials anticipate implementation in July 2005 and that coverage will eventually reach an estimated 40,000 uninsured New Mexicans.

Arkansas

Arkansas officials are still awaiting CMS approval of their waiver, which has components very similar to Maine and New Mexico's programs. Substantive development of Arkansas's waiver started in 2001 by the state's Department of Human Services and in 2002 by the HRSA- and SCI-supported Arkansas Health Insurance Expansion Initiative Roundtable. A waiver application was submitted in January 2003.

The state's original proposal was to make the program available to Arkansas residents of all incomes through a newly developed "safety net" benefits package and to provide subsidies to those with family incomes at or below 200 percent FPL. Employers eligible for the employer-based program are those that have not offered group health insurance for the 12 months prior to program enrollment and that guarantee 100 percent employee participation. Under the proposal, the state would receive federal matching funds for eligible adult workers and their spouses with family incomes less than 200 percent FPL.

Unlike traditional premium assistance programs, New Mexico's program creates a new insurance product for small employers. The state designed a benefit package that is more in line with commercial insurance than Medicaid benefits.



"Our purpose, this year, is to set the stage constructively for purposeful, productive compromise and action next year, no matter who is leading the nation."

— Risa Lavizzo-Mourey, M.D., M.B.A.
President, The Robert Wood Johnson Foundation

On May 10, 2004, The Robert Wood Johnson Foundation launched its second "Cover the Uninsured Week" (CTUW), a national effort to mobilize physicians, employers, policymakers, and other stakeholders on behalf of the nation's 44 million uninsured. Through more than 2,700 events across the country, the Foundation's goals were to reverse the trend of the rising uninsured, elevate the issue on the national and local agendas, educate Americans about the problem, and provide immediate assistance to the uninsured and small-business owners. Presidents Carter and Ford chaired the effort for the second year.

Nearly 250 national organizations and more than 2,500 local organizations—including 25 professional sports teams—sponsored local activities, such as health and enrollment fairs for uninsured Americans and health coverage seminars for small-business owners. In Utah, as many as 10,000 children were enrolled in the State Children's Health Insurance Program (SCHIP) or Medicaid during the week. The state hosted two campus outreach events prior to the campaign's kickoff on May 10, an interfaith outreach event, two press conferences, multiple health fairs, and a small-business seminar.

In Manhattan, musicians, and stars of stage and screen put on a "Unity Concert" to celebrate the effort of the CTUW coalition. Stories of the uninsured were read throughout the performance. It was one of 600 events hosted throughout New York City. In Portland, the Oregon Health and Science University's Cover the Uninsured event featured a panel discussion designed to inspire medical students, physicians, and other health care providers to become involved in working with the uninsured. Speakers included former Governor John Kitzhaber, M.D. In Minneapolis, Southside Community Health Services provided free dental services to the uninsured.

The Week's efforts paid off not only in terms of getting people enrolled in public or private coverage, but also in bringing the plight of the uninsured into America's living rooms. Public service announcements were broadcast featuring television stars Noah Wyle, who served as campaign spokesperson, Marg Helgenberger, and Jane Kaczmarek in key markets, such as Boston, Denver, Miami, New Orleans, and San Francisco.

Nearly 20,000 people called the campaign's toll-free hotline and nearly 1.7 million copies of Cover the Uninsured Week materials were requested. Also, the campaign's

Web site (<http://covertheuninsuredweek.org>) received more than 370,000 new visitors between September 1, 2003, and September 1, 2004.

Unfortunately for many Americans, health insurance is simply out of reach. According to the U.S. Census Bureau, as many as 8 in 10 uninsured individuals are in working families, yet they cannot pay the high premiums imposed as a result of skyrocketing health care costs. Their families earn too much to be eligible for public programs, so there is nowhere to turn, except the safety net. Similarly, employers are having a difficult time providing health insurance to their workers, even though they want to help offset the costs. As a result, employer-sponsored insurance is declining.

As part of the week's activities, organizers asked policymakers to consider new legislation that would help make insurance a reality for those currently unable to afford it or those ineligible for public programs. For a complete list of proposed legislation, see <http://covertheuninsuredweek.org/legislation/>.

"The Robert Wood Johnson Foundation believes that if we are to solve this problem, we must transcend ideologies, partisan politics and single, entrenched solutions," says Lavizzo-Mourey. "We need a commitment, from all Americans—our elected leaders, consumers, physicians, hospitals, insurers, business owners, religious leaders, and others—that solving this problem will be the top domestic priority in the coming year." Plans for Cover the Uninsured Week 2005 are underway.

Further Resources

Alliance For Health Reform and The Robert Wood Johnson Foundation, *Health Care Coverage in America: Understanding the Issues and Proposed Solutions*, <http://covertheuninsuredweek.org/materials/files/IssuesGuide.pdf>.

State Guides to Finding Health Insurance Coverage <http://covertheuninsuredweek.org/stateguides/>

Guide to Health Insurance Options for Small Businesses <http://covertheuninsuredweek.org/materials/business/>

Health Care Coverage in America Presentation <http://covertheuninsuredweek.org/materials/files/HealthCareCoverage.ppt>.

Actuarial analyses have demonstrated that the proposed “safety net” benefits package will cover the majority of anticipated utilization of services. Services included in the proposed package are six clinic visits, seven inpatient days, two outpatient surgeries per year, and two prescriptions per month.

Since submitting the waiver, CMS officials have conducted a series of calls and meetings with Arkansas representatives to identify legal and procedural impediments to approval. They also clarified mechanisms to address these roadblocks, including the need to demonstrate clearly that state dollars serve to draw down federal match. As a result of these discussions, Arkansas officials revised the original application and resubmitted it to CMS in October 2004. At the time this report went to press, state representatives were optimistic that CMS will give a rapid and positive response.

“The process has taken longer than was predicted,” says Kevin Ryan, associate director of the Arkansas Center for Health Improvement. “However, the fact that it continues to move forward demonstrates the commitment and resolve of both state and federal officials to develop mechanisms to address the uninsured.”

Both Virginia and Louisiana also submitted HIFA waivers in fall 2004. Louisiana’s waiver, LaChoice, would provide a subsidy to employers with fewer than 50 workers to provide health benefits for their employees. Virginia’s waiver proposes expanding public sector coverage for pregnant women from 133 to 200 percent FPL to cover prenatal care, delivery, and post-partum care. The waiver also would simplify the state’s existing premium assistance program.

Ballot Initiatives

As an election year, 2004 gave voters the opportunity to propel states forward on their coverage programs. Voters made their opinions known on coverage-related initiatives in four states: California, Colorado, Oklahoma, and Montana.

California

California’s controversial “pay or play” measure failed by a slim margin. Had the initiative passed, the mandate would have required certain large employers to provide health insurance to workers or pay into a state fund to provide coverage. The requirement would have extended to mid-sized employers over time.

Colorado

Voters in Colorado overwhelmingly approved a tobacco tax hike that will bring in \$175 million to be used toward specific health spending priorities. Forty-six percent of the funds will be dedicated to increasing eligibility of low-income children, their parents, and other adults covered by Medicaid and SCHIP.

Oklahoma

Oklahoma residents also voted to approve a tobacco tax increase. Part of the funds generated through the increase will go toward a pilot program to provide incremental coverage to 100,000 uninsured working adults and their dependents. The program will allow individuals working for small businesses with less than 25 employees to access health insurance for their families. Officials hope to implement this program through a HIFA waiver. The coverage model was developed in part as a result of Oklahoma’s HRSA State Planning Grant, which helped to crystallize the state-level issues related to the uninsured and engaged many stakeholders.

Montana

Voters in Montana also approved by a wide margin a tobacco tax increase that will bolster the state’s health programs. The increase will provide new funding for Montana’s SCHIP program; allow for the creation of a prescription drug program to serve children, seniors, and the chronically ill and disabled; and possibly support development of a coverage program for small businesses.

The tax revenue may also fund the establishment of a tax-credit program to assist small businesses with the cost of health insurance. Approximately 60 percent of Montana small businesses do not offer coverage.

Preliminary plans indicate that the tax credits would be available for small groups with nine or fewer employees (which is the predominant size of small businesses in the state), and would give preference to groups with two to four employees. The tax credit would be:

- ◆ Refundable and advanceable;
- ◆ Available to small businesses on a sliding scale, depending on the average age of the group;
- ◆ Significant enough so that small business owners have an incentive to participate in the program; and
- ◆ Valid up to an income limit of \$150,000 for any employee or employer.

As an election year, 2004 gave voters the opportunity to propel states forward on their coverage programs. Voters made their opinions known on coverage-related initiatives in California, Colorado, Oklahoma, and Montana.

Although the initiative passed, it must be approved by the Montana Legislature, which meets in January 2005.

Building on the Safety Net

As in the past, in 2004 some states made it a priority to build on their safety-net programs and other community-based vehicles to provide coverage and reduce costs. Many states have long been interested in pursuing community models aimed at reducing the number of uninsured. One of the pioneers of community-level initiatives is Michigan's Muskegon County three-share program, which leverages the cost of health coverage among workers, employers, and county funds. Similar models are being developed and/or implemented in communities in a number of states, including Arkansas, Florida, Illinois, Iowa, Louisiana, Maryland, Virginia, and West Virginia.

Likewise, at least 20 states have organized community-based systems of care for the uninsured. Such programs are financed through various federal and state sources as well as Medicaid funds, local government finances, local employer assets, family contributions, and philanthropy. Florida's Health Flex plan is an example of such a program that takes advantage of county resources to offer access to care that emphasizes coverage for basic and preventive health care services.

Currently, four of five licensed Health Flex plans are running in the state. The biggest challenge faced by the plans is enrolling individuals. The plans have found that the population targeted for the program also has access to safety-net programs in the state. The availability of free care reduces their incentive to pay for the same types of services.

HOW FEDERAL REFORMS AFFECTED STATES

In late 2003, Congress passed the long-anticipated Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (MMA), which for the first time provided seniors and people living with disabilities a prescription drug benefit under Medicare. A year later, state officials were still sorting out the implications of two main aspects of the legislation: the Part D drug benefit, which will take effect in 2006, and the drug discount card and transitional assistance program, which began in June 2004.

The legislation also included a provision authorizing people to establish health savings accounts, which combine a high-deductible catastrophic health insurance plan with a tax-preferred savings account for individuals under the age of 65. Although the accounts were legislated through a federal initiative, states play several roles in their implementation.

Medicare Drug Discount Card and Transitional Assistance Program

The Medicare-endorsed discount card and the transitional assistance program is intended to be a transitional step that will afford beneficiaries prescription drug savings while they await implementation of the full benefit, which begins January 1, 2006. It is an 18-month interim program that began in June 2004.

Enrollees can sign up for only one card, and the program is administered privately by 27 card sponsors. The card is estimated to give consumers a 10 to 25 percent discount in the retail price of prescription medications.

In some cases, states also stand to benefit from the card and transitional assistance. About half the states in the country already operate prescription drug programs (State Pharmacy Assistance Programs, or SPAPs) that are financed solely by state funds. By coordinating the discount card program with their SPAPs, states can receive supplemental federal funds that could translate into state savings. However, not all SPAP enrollees are eligible for transitional assistance in the discount card program. Moreover, coordinating the programs

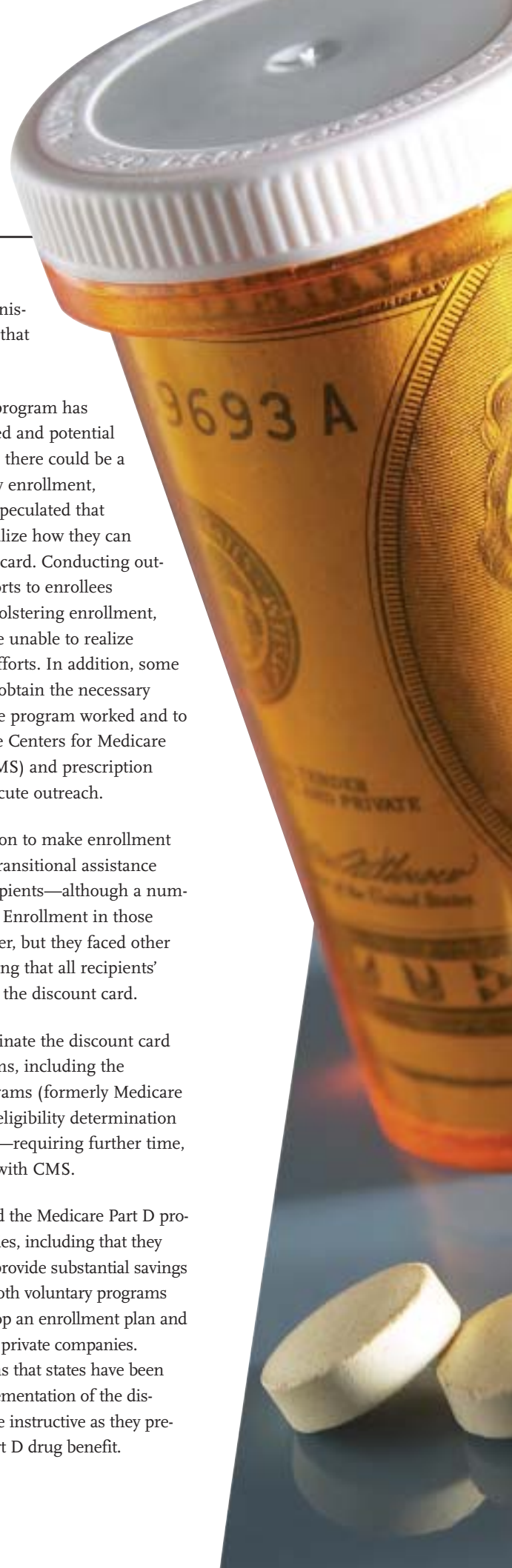
may involve making administrative changes with costs that could counter the savings.

So far, enrollment in the program has been lower than anticipated and potential savings are unclear. While there could be a number of reasons for low enrollment, some policymakers have speculated that recipients simply don't realize how they can benefit from the discount card. Conducting outreach and educational efforts to enrollees appears to be critical for bolstering enrollment, although many states were unable to realize increases despite strong efforts. In addition, some states found it difficult to obtain the necessary information about how the program worked and to whom to target it from the Centers for Medicare and Medicaid Services (CMS) and prescription drug plans in order to execute outreach.

Few states passed legislation to make enrollment in the discount card and transitional assistance compulsory for SPAP recipients—although a number of them considered it. Enrollment in those states' programs was higher, but they faced other challenges, such as ensuring that all recipients' drugs were covered under the discount card.

Officials also had to coordinate the discount card benefit with other programs, including the Medicare Advantage programs (formerly Medicare + Choice), and with their eligibility determination for transitional assistance—requiring further time, money, and coordination with CMS.

The drug discount card and the Medicare Part D programs have some similarities, including that they both have the potential to provide substantial savings for SPAPs. They are also both voluntary programs that require states to develop an enrollment plan and to coordinate benefits with private companies. Consequently, many lessons that states have been learning through the implementation of the discount card program may be instructive as they prepare to supplement the Part D drug benefit.



Some of those lessons were highlighted at an October 2004 invitational summit held by AcademyHealth and the Rutgers Center for State Health Policy in Philadelphia. Kimberley Fox of the Rutgers Center for State Health Policy made the following preliminary observations:

- 1) With regard to coordinating benefits, states will likely achieve more savings working with a preferred card/program than trying to coordinate multiple programs or coverage options.
- 2) The most efficient way to ensure enrollment for those deemed eligible is auto-enrollment. States will need to decide whether to retain a voluntary program or to pass legislation to make it automatic and/or mandatory. It will be imperative for CMS officials to build enough time into the implementation process so that states can change legislation to allow auto-enrollment.
- 3) States should explore all “wrap-around” coordination options and exercise the appropriate ones to reduce administrative burdens.
- 4) Perhaps most important, effective coordination is required among CMS and the states in sharing information related to eligibility requirements and proper outreach to enrollees.

The Medicare Part D Drug Benefit

The new Medicare drug benefit will significantly affect dual eligibles—individuals who qualify for both Medicaid and Medicare. Over the past

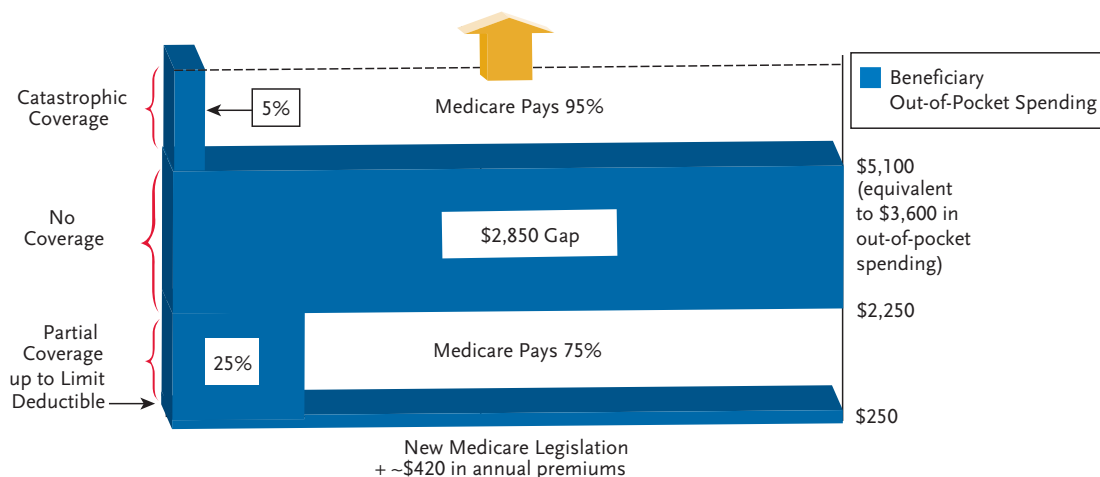
decade, much of the rising costs in Medicaid programs can be attributed to prescription drug spending by dual eligibles—an older, often disabled group that has increased in size as the American population has aged.

As of January 1, 2006, Medicaid will no longer be responsible for providing this group's prescription drug coverage. Instead, many dual eligibles will get such coverage through Medicare private plans. Dual eligibles and many other low-income beneficiaries will be eligible for low-income subsidies in addition to part D coverage. However, dual eligibles and other low-income Medicare beneficiaries will have to enroll in these private plans. Depending on state implementation decisions, low-income beneficiaries who fail to enroll in plans may be auto-enrolled.

Under the law, CMS and the Social Security Administration (SSA) must approve individuals' eligibility for Part D. But the details of this new administrative structure have yet to be worked out. Some fear that dual eligibles could end up without any prescription drug coverage during the critical transitional period to the new program. “Medicaid prescription drug coverage stops January 1, 2006, whether consumers, states, or prescription drug plans are ready or not,” says Ohio Medicaid Director Barbara Coulter Edwards.

Implementing some facets of Part D will be particularly difficult considering that state Medicaid budgets for 2006 are projected to be even tighter than they are now. “There are major costs associ-

Figure 8: Medicare Beneficiaries' Out-of-Pocket Drug Spending Under New Medicare Rx Benefit, 2006



Source: “The Medicare Prescription Drug Law-Fact Sheet,” #7044, The Henry J. Kaiser Family Foundation, March 2004.

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ated with the Medicare drug benefit,” says Vernon Smith of Health Management Associates. “States will have a large amount to pay into the benefit and we will need to look closely at the dual eligible population to control costs.”

State officials are particularly concerned with the “clawback” feature in the Medicare legislation, which requires states to repay the federal government a substantial portion of their savings from financing drugs for the dual eligibles once the new program is implemented. The formula that states must use to determine savings is based on a 2003 baseline of states’ Medicaid drug expenditures for dual eligibles—which could, some policymakers believe, hold states to a higher-than-actual level of spending.

“I don’t think anyone’s base year will reflect the way things will be done in 2006,” says Smith, citing the sentiments of Medicaid directors across the country who were interviewed about the Part D benefit by Health Management Associates.

Some officials question the fairness of this provision because they view it as an unfunded mandate. “We’re responsible for helping the federal government to implement this new benefit with no budget for the effort,” says Rhode Island Medicaid Director John Young. Rhode Island has worked hard over the past five years to curb pharmacy growth. “We’re at a disadvantage because the clawback provision does not give us credit for this effort,” he adds.

Moreover, many policymakers are anticipating that states will be further burdened financially due to the “woodwork effect”—a surge in Medicaid enrollment that may occur as more low-income Medicare beneficiaries realize that they are eligible for both programs.

States that already operate state-only prescription drug programs must also sort out whether and how to coordinate their existing program with the new benefit. Many states have already started to plan how they will supplement the Part D prescription drug benefit. According to Kimberley Fox, examples of state decisions may include:

- 1) Whether to work with multiple plans or one preferred plan;
- 2) Whether to make enrollment in Part D required for SPAP enrollees and when to time the implementation accordingly; and

- 3) Whether to use capitation or a “wrap-around” mechanism for transitional assistance, and which elements to wrap around (e.g., cost-sharing or formularies and networks).

Each decision carries with it advantages and drawbacks. For example, many states like the idea of filling in gaps or subsidizing payments so that low-income Medicare beneficiaries have more comprehensive coverage. However, states would need to put their own dollars at stake to do this, as they cannot receive a federal funding match for wrapping around Part D.

Effective collaboration and communication among states, CMS, and SSA will be critical to successfully implementing the Part D drug benefit. State officials will also need to coordinate with prescription drug plans in order to attain the appropriate data to ensure eligible individuals are enrolled in the program. In addition, proper education and training of personnel—as well as outreach to beneficiaries—is crucial. Perhaps most important, states will need to use the resources available to them to the fullest extent to make the most informed and appropriate decisions.

Health Savings Accounts: A Trend toward Consumerism

The MMA also created health savings accounts (HSAs)—the most recent version of individual health reimbursement accounts that include an account coupled with a high-deductible health plan. HSAs are part of a trend toward promoting broader consumer financial participation in health care decisions. Although it is too early to assess their impact, the hope is that HSAs will reduce the rate at which health care spending has been growing. As of January 1, 2004, individuals and employers could start making contributions to these accounts. (For more on how HSAs operate and differ from other individual health reimbursement accounts, see Figure 9 on p. 27.)

Because HSAs and other consumer-driven health plans (CDHPs) give consumers more control over how their health care dollars are spent and generally provide information to help them make these choices, some experts believe the plans will lead people to make more cost-effective choices. However, others fear that CDHPs’ high deductibles and out-of-pocket costs could prevent patients from obtaining necessary care and increase expenditures in the long run.

In their roles as health insurance regulators and purchasers, states can influence whether and how HSAs operate in their markets.

States as Purchasers

Like other employers, states may consider HSAs as an option for covering state employees. For example, in 2004 Louisiana passed legislation authorizing state and local government entities to establish HSAs for their employees. Other states may follow suit.

Preliminary evidence suggests that HSAs disproportionately attract healthy individuals—which may drive up health care costs for the less healthy people inclined to remain in traditional plans. Thus, states that decide to offer HSA products to their employees may need to consider risk-adjustment mechanisms to help avoid adverse selection.

Because many state workers are unionized, union negotiators and leaders are likely to challenge states that tout the advantages of HSAs. In messages to union workers, for example, the president of the Oregon AFL-CIO has stated that HSAs favor high-income, healthy individuals at the expense of less healthy, low- and moderate-income individuals (a group that includes many union workers). Similar warnings were issued in Washington state to the UFCW Local 1001.

States as Regulators

State officials may need to make legislative and regulatory changes in order to accommodate these accounts in their markets. They must assess tax laws and benefit mandates to ensure that state rules coincide with federal rules relative to the structure of the high-deductible health plans (HDHPs) that accompany the accounts. For example, does state law require certain services to be covered without a deductible or are there deductible limits that differ from the federal definition of an HDHP?

According to the National Conference of State Legislatures, HSA-related bills have been filed in more than 20 states in the past year, at least four of which have been signed into law. These legislative proposals enable plans to be sold in their market that conform to the federal rules for HDHPs that accompany HSAs.

State budgets could be affected by the change in federal tax policy. Deposits to and withdrawals from HSAs for certain medical expenses are exempt from federal taxes, but subject to state income tax unless the state enacts an exemption. A reduction in taxable income could reduce state tax revenue, depending on whether the state uses federal definitions as the basis for their personal and corporate income taxes.

What Are HSAs and How Do They Work?

HSAs are financial accounts that must be coupled with a high-deductible health plan (HDHP). As tax-free accounts, they can be used to pay for certain medical expenses and are available to any individual who is insured under an HDHP that meets specific guidelines and who is not simultaneously covered by other health insurance or on Medicare.

Contributions may be made to the account by employers or individuals; the account is fully owned by the individual and portable. The monies can be used for anything. They are distributed on a tax-free basis for medical expenses; if used for non-medical expenses, they are subject to penalties or taxes.

In order to qualify for an HSA, an individual must be covered under a high-deductible plan, which must have a minimum deductible of \$1,000 for individuals and \$2,000 for families. Once funds from the HSA are depleted, the high-deductible insurance policy provides coverage with varying cost-sharing amounts. The gap between the annual contribution to the HSA and the deductible is covered out of the consumer's own pocket. The maximum out-of-pocket spending can be no more than \$5,000 for individuals and \$10,000 for families.

Figure 9: Comparison of HSAs, MSAs, FSAs, HRAs

	HSAs	MSAs*	FSAs	HRAs
Health plan type	High deductible only	High deductible only	High deductible and comprehensive	High deductible and comprehensive
Carryover from year to year	Yes	Yes	No	Yes
Individual owns account (keep even after leaving job)	Yes	Yes	No	No (up to employer if individual allowed access to HRA after employee leaves)
Type of coverage?	Individual and job-based health coverage	Small business or self employed health coverage only	Job-based only	Job-based only
Who contributes?	Individuals, employees, and employers	Employee, self-employed person or small business employer (50 or less employees)—both employee and employer cannot contribute in a tax year	Employee	Employer
How is it taxed?	"Above-the-line deduction" (employer contribution not taxed as income)	"Above-the-line deduction" (employer contribution not taxed as income)	Not taxed as income	Not taxed as income

*No new MSAs (Archer MSAs) allowed after December 31, 2003.

However, some states may choose to further encourage HSAs by providing a state tax exemption. House representatives in Pennsylvania recently proposed legislation to provide a state tax exemption in accord with federal law regarding HSAs.

Whether HSAs help or harm health insurance markets can vary by state. Thus, officials will need to monitor the mix of insurers in their markets, identify the best mechanisms to pool risk, and watch for changes in coverage in their individual and small group markets.

The speed with which insurers in each state will offer HSAs in 2005 is not clear, but they are likely to be offered nationwide by 2006. According to a 2004 Milliman Consultants and Actuaries survey, nine out of 10 health insurers expect to offer an account-based CDHP within one year.

So far, employers' response to HSAs is best described as cautious but curious. In the 2004 Annual Employer Health Benefits Survey, the Kaiser Family Foundation and Health Research and Educational Trust reported that about 6 percent of all firms (accounting for 13 percent of covered workers) said that they are "very likely" to offer a high deductible plan/savings account option in the next two years, while 21 percent of all firms—accounting for 26 percent of covered workers—said they are "somewhat likely" to offer such an option. However, most national health plans report that they will have products on the market by 2006, and employers are likely to consider them in 2005 for the following year.

As HSAs are still an unknown commodity, state insurance commissioners may increase their financial oversight on carriers offering products coupled with these accounts. In states that require or

Preliminary evidence suggests that HSAs disproportionately attract healthy individuals—which may drive up health care costs for the less healthy people inclined to remain in traditional plans. Thus, states that decide to offer HSA products to their employees may need to consider risk-adjustment mechanisms to help avoid adverse selection.

Source: Kofman, M. Health Savings Accounts: Issues and Implementation Decisions for States, *State Coverage Initiatives program Issue Brief*, September 2004.

Early Lessons from the Trade Act of 2002

It's been more than two years since President Bush signed the Trade Act of 2002 into law. For health policy-makers, perhaps the most closely watched outcome of this legislation was the new system of Health Coverage Tax Credits (HCTCs) that it created. The credits pay for 65 percent of the cost of health insurance premiums for a small group of workers displaced by international trade and early retirees who receive a federal pension from the Pension Benefit Guaranty Corporation. An estimated 230,000 individuals nationwide were identified as potentially eligible for HCTCs in July 2004.

This aspect of the Trade Act is significant because it provides the first U.S. experiment in about a decade with fully refundable and advanceable federal income tax credits for health insurance—a concept that has resurfaced many times over the years as a potential mechanism for addressing the uninsured. As state policymakers consider tax credits as a means of expanding coverage, the HCTC experience may offer lessons about implementation challenges.

Preliminary evidence suggests that the credits are off to a slow start. For example, in July 2004, only 13,200 were enrolled in HCTC advance payment. More than 12,000 workers claimed HCTCs only on their annual tax forms for 2003. However, it may still be too soon to reach any definite conclusions about take-up, especially considering that advance payment under the program did not start until August 2003.

Recent research supported by The Commonwealth Fund and The Nathan Cummings Foundation provides a useful early analysis of the HCTCs. Preliminary findings and lessons to guide future reforms are summarized in an April 2004 report written by Stan Dorn and Todd Kutyla of the Economic and Social Research Institute. The report's key findings are as follows:

Federal officials have made substantial progress in establishing the infrastructure to support the program.

- ◆ They were able to meet the statutory deadline of August 1, 2003, for advance payment. To accomplish this, they created a mostly electronic system for exchanging information and payments, and collaborated across multiple federal, state, and private entities.
- ◆ The officials who created the program have been nimble and creative. For example, grants from the Department of Labor were used to mimic the effects of tax credits and to pilot test advance-payment systems in two states.

Relatively few eligible individuals have taken up health care tax credits.

- ◆ Affordability may be an obstacle. For many unemployed individuals and early retirees, even 35 percent of a health insurance premium is prohibitive. The 35 percent premium cost of \$1,713 per year would consume 5 percent of the total annual income for a four-person family at 200 percent of the federal poverty level.
- ◆ The timing of the advance payment may be another enrollment barrier. Beneficiaries must first enroll in a health plan and pay full premiums for a month or more until advance payment starts. Although they can receive a refund for these costs with their year-end tax refund, many cannot afford to front the initial payments.
- ◆ Many eligible workers may not receive the information they need to enroll. The 20-page brochure typically mailed to eligible individuals is complex and difficult to understand. Moreover, not all potentially eligible beneficiaries receive it; recently displaced workers who are still receiving unemployment insurance are not on the eligibility lists on which such mailings are based.

The administrative costs of the tax credits may be high.

- ◆ However, it is not yet clear whether the new tax credit infrastructure can be expanded to a larger population at marginal cost, or if high administrative costs will translate into high operational costs that grow in proportion to the number of people served.

The health plans offered through the program are heterogeneous.

- ◆ In states offering qualified coverage, there was a roughly 50/50 split between those that used COBRA plans and those that used state-qualified plans. COBRA plans are feasible only when the firm that had employed trade-impacted workers itself does not fail, and therefore can continue to offer coverage to workers who have lost their jobs.
- ◆ State-qualified plans included mini-COBRA plans in nine states that have extended federal COBRA provisions to firms with fewer than 20 employees, non-group plans with underwritten premiums in 11 states, high-risk pools in 13 states, and community-rated plans in six states.

For a follow-up report in which Stan Dorn outlines options for modifying the tax credit program based on early findings, please visit: www.esresearch.org/newsletter/trade_act_options.pdf.

encourage minimum loss ratios, regulators may wish to set separate loss ratio standards for HSA plans, as the risk they entail becomes more apparent. There is some movement in Congress to create greater collaboration among states on issues related to insurance regulation.

Finally, it is also too early to know how consumers themselves will react to HSAs and how that might translate in terms of complaints fielded by state insurance departments. Employers that do a full replacement of health benefits with one HSA plan may experience the greatest backlash if employees are dissatisfied. However, the early evidence shows equal or greater satisfaction among consumers who have chosen these options over traditional preferred provider organization or health maintenance organization plans.

Consumer Response, Information Needs, and Impact on Coverage

In order for HSAs to be effective, the American public must adopt a new mindset about health care. The concept of paying the full cost of an office visit rather than a co-pay is a change from the trend of the past 20 years. Thus, consumers will need to understand the true costs of health care in order to make fiscally wise and quality-focused choices.

In order to make informed decisions, consumers will need access to print and/or Web-based educational tools that provide clear, evidence-based information about health care costs and quality. There are already efforts in some states to provide residents with such materials. In addition, many health plans are offering decision tools along with the HSAs (or other account-based plans), and states will need to monitor that information.

Whether HSAs can help states with the intractable dilemma of the uninsured is not yet clear. The answer will likely depend on the price of HSAs and whether employers who have not offered coverage in the past will offer these plans, and whether employees who have not previously accepted coverage will now take-up an HSA-compatible high deductible health plan.

The barriers for uninsured individuals without employer-sponsored coverage are significant. The individual market is small and those in it typically have higher health care needs than the average population. Many may find the high deductibles associated with these plans unappealing, although the lower premium may be more affordable with the added benefit of tax-free savings to cover future health care expenses.

PRIVATE INSURANCE MARKET TRENDS AND STATE REFORMS

Over the past several years, private insurers and employers across the country have struggled with the same rising health care costs and dwindling economy that states have faced. This cost growth has contributed to an erosion in private coverage—which often translates to a reduction in family coverage as employees as well as their spouses and dependents lose insurance. The percentage of all workers who received insurance through their employer dropped from 65 percent in 2001 to 61 percent in 2004, according to a survey conducted by the Kaiser Family Foundation and Health Research and Educational Trust (HRET).

However, like states, private insurers and employers saw in 2004 the first glimmer of improvement in cost growth trends in years, although the road ahead remains uncertain. Private health insurance premiums rose 11.2 percent in 2004, according to the Kaiser/HRET survey. Although this rate of increase is less than that from 2003 (13.9 percent), 2004 marks the fourth consecutive year of double-digit growth. Moreover, the 2004 increase is about five times the rate of inflation and workers' earnings.

Officials in some states took a hard look at the underlying reasons for private-sector cost increases and tailored their approaches to address them.

However, most state strategies focused on how to make insurance more affordable.

Many considered legislation to allow insurance carriers to sell scaled-back benefits plans to small groups as a way to improve health care

access and affordability. Others

have revisited the concept of reinsurance to spread risk in insurance markets, improve the predictability of claims, and reduce the mark-up of premiums that insurers charge as a buffer against unanticipated claims.

Strategies to Address Cost Growth

According to the Center for Studying Health System Change, rising premiums are a result of the underlying cost increases for hospitals, physician care, and prescription drugs. For their part, states looked at a number of approaches to slow this cost growth. For example, through the Dirigo Health Reform Act, Maine officials sought to control capacity by reactivating certificate of need. Further, they have asked insurers, hospitals, and other providers to voluntarily limit their cost growth to 3.5 percent and are encouraging greater transparency in health care pricing and insurance premiums to foster informed consumer behavior.

Officials in Indiana are assessing their state's cost drivers through a Health Resources and Services Administration State Planning Grant project; the effort represents a first step toward developing strategies to address costs in the state. Iowa has approached the cost problem by drawing attention to the drag on its economy created by rising health insurance premiums. In 2004, the Maryland Legislature required the Maryland Health Care Commission to study issues related to the affordability of health insurance in that state. It examines the impact of several cost drivers, including the retreat from managed care, growth of technology, and increasing populations with chronic conditions.

More generally, state officials are assessing whether to promote consumer-directed health plans, which give consumers a greater stake in their health care costs, as a potential incentive to lower costs. (See p. 26 of Federal Reforms for more information about consumer-directed health care.)

Limited Benefits Plans

States have mandated that private group carriers cover certain benefits for more than three decades. Individual insurance is typically exempted from these requirements, except in states that have defined a standard individual benefit to encourage greater price competition in the individual market. The type of mandated services varies by state, but all states require group coverage of newborns without preexisting condition exclusions, and many require coverage for items such as mammography and diabetes supplies.



INSURANCE
COST

Mandated benefits have been criticized for adding to health care costs, but a 2000 Congressional Budget Office report concluded that mandating benefits would only increase premiums by 5 percent. As costs have risen and coverage has eroded, many officials have begun to explore whether relaxing state mandates might help to make health insurance more affordable, particularly for small employers and their employees.

Arkansas, a state that has had a mandate-free plan on the market since 2001, has seen low enrollment in the plan. Officials attribute this to minimal savings achieved by sharing mandated benefits. “It does not create enough of an incentive for employers to change the plan they offer to employees,” says Jim Bailey, regional executive for Arkansas Blue Cross Blue Shield, “and it is not cheap enough for those not offering any coverage currently.”

To date, at least 12 states have enacted minimum benefit legislation allowing insurance carriers to sell plans with scaled-back benefits in the private market; four states—Louisiana, Maryland, Texas, and Washington—passed such legislation in 2004. In states where insurers have filed and begun to sell limited-benefits products, including New Jersey and Montana, take-up has been remarkably low, but the plans have only been on the market for a short time.

New Jersey

In March 2004, the boards of the New Jersey Individual Health Coverage program (IHC) and the Small Employer Health Benefits program (SEH) submitted a report to the New Jersey governor and legislature to evaluate the effectiveness of the state’s limited benefit legislation, referred to as the “Basic and Essential Health Care Services Plan,” or the “B&E Plan.” Based on six months of data, the evaluation concluded that B&E was modestly effective in increasing enrollment and reducing the number of uninsured in the state.

As of July 2004, B&E’s enrollment of 1,387 people was covered primarily by two carriers. The report stated that younger enrollees benefited most from B&E; the plan was appealing to them because carriers were using modified community rating to set premiums—which favors younger, healthier individuals. All other products in the state’s market are pure community-rated.

According to Wardell Sanders, executive director of the IHC and SEH boards, anecdotal evidence suggests that carriers were generally reluctant to sell these plans due to the potential for consumer confu-

sion. In addition, brokers were afraid that they could face lawsuits if consumers needed a benefit that was found in New Jersey’s standardized health benefits plan, but not covered in B&E.

Montana

With less than a year’s experience on the market, Montana’s limited coverage individual health benefit plan has been tested by only one carrier, New West Health Services. The state legislature enacted a statute in 2003 allowing insurers to offer the plan via a renewable 12-month demonstration project for a maximum of five years. New West’s Bridge Plan has an enrollment cap of 1,000, and has no deductible or restrictions for pre-existing conditions. Members have a copayment and deductible based on household income. The plan provides unlimited office-based care, lab and x-ray services, generic prescription medications, and outpatient therapies including mental health visits.

When it became available, the state received more than 400 requests for applications. However, to date the plan has enrolled only 53 people. The low number of buyers seems to reflect consumers’ desire for more comprehensive packages. “After interested individuals reviewed what was on the plan, they realized that the package didn’t cover enough to be of value to them,” says Colleen Senterfitt, director of Health Care Access at New West.

Based on state legislation, carriers could only sell the plan in the individual market, as legislators feared that, if it were available more broadly, employers would drop their existing coverage in favor of the lower-cost, limited coverage plan. After discussing the issue with small employers, Senterfitt suspects that enrollment might have been much higher had employers not previously offering coverage been allowed to participate.

Reinsurance

The concept of reinsurance—in which states assume a portion of insurers’ high-cost claims—has been around for decades, but many states abandoned their reinsurance programs as discussion of national health reform increased in the 1990s. Recently, however, reinsurance has reemerged as a potential mechanism to support small-group coverage, improve individual access to coverage, or both. Many states operate unsubsidized reinsurance programs that have very low enrollment. However, a small number of states operate subsidized programs for low-wage small groups and self-employed workers; these have somewhat greater enrollment.

Lawsuits Challenge Non-Profit Hospitals on Provision of Charity Care

Are the Uninsured Being Charged More than Other Patients?

Whether employed or unemployed, insured or uninsured, many Americans are feeling the pinch of two factors leading to unprecedented debt due to medical bills: increasing numbers of uninsured individuals and rapid growth in health care costs. Medical debt takes a societal toll as it places financial strain on vulnerable families and discourages patients who are unable to pay for care from accessing it when they're sick. Debt related to medical care is a leading reason for filing personal bankruptcy, even for individuals with insurance.

Research conducted by The Access Project in Boston and partners at the Heller Graduate School at Brandeis University found that, out of 342 clients of community health centers in Lynn, Mass., and Dorchester, Mass., 41 percent reported having medical debt. Three-fifths of them said that it caused them to delay getting needed care, according to a press release from The Access Project.

For uninsured individuals, seeking medical care is especially daunting. Not only must they navigate the health care system to find a facility that will treat them, but many found in 2004 that they were charged higher prices at some hospitals than other patients for the same services. Lawyers and private citizens filed hundreds of lawsuits in 2004 against non-profit hospitals, claiming that the uninsured are charged more because they do not have access to negotiated discounts. The legal question is whether non-profit hospitals—as tax exempt, 501 (c)(3) organizations—violate their obligation under Internal Revenue Services (IRS) rules to provide a community benefit by charging prices that uninsured patients clearly cannot pay.

"The uninsured are expected to pay the 'rack rate' since they do not enjoy discounts negotiated by insurers or set by the government," says Mark Rukavina, executive director of The Access Project, which advocates for the uninsured. Non-profit hospitals that charge this group more, say advocates for the uninsured, are essentially operating like for-profit enterprises.

"A charity hospital charging charity patients more than they charge anyone else doesn't sit right with folks," says Richard Scruggs, the lead attorney in many of the suits. "It's hard to defend." Scruggs and his Mississippi-based law firm gained national notoriety as the lead firm in the tobacco settlement litigation that ultimately led to the Tobacco Master Settlement Agreement.

The IRS doesn't prescribe a minimum charity care requirement—it is fulfilled simply by providing health care services—and the term "community benefit" is loosely defined and varies among states. "This so-called community benefit standard is such a low bar that anyone in business could meet those standards," adds Scruggs. "There hasn't been a single hospital ever that's had its federal exemption revoked. The law has been passed for the benefit of the people, but there's no enforcement."

So far, states themselves have not been involved as plaintiffs in the suits, although they are reacting to the problem in other ways. In August, the California Legislature passed a bill that would require hospitals in the state to provide financial assistance in the form of

charity care or payment allowances to uninsured patients whose income is at or below 400 percent of the Federal Poverty Level (FPL). In a letter to Governor Arnold Schwarzenegger (R), Mitchell Katz, director of health in San Francisco's Department of Public Health, pointed out that non-profit hospitals are exempt from paying property and income taxes, and have access to low-cost financing for facility constructions and renovation. Their favorable tax status, he says, comes with an obligation to care for those needing care regardless of income or health insurance status.

In September, Governor Schwarzenegger vetoed the bill, stating that guidelines adopted voluntarily by the state's hospital community in February to assist low-income uninsured Californians must be given time to be implemented and reviewed. Similarly, officials in Alabama, Georgia, and Illinois considered legislation in 2004 that would either prohibit hospitals from charging uninsured individuals more than what other patients pay or require hospitals to develop policies that would assist uninsured patients in paying their bills, according to a November 29, 2004, article in *State Health Notes*.

The hospitals and their supporters have called the lawsuits a distraction, claiming that they disguise the real issue, which is how to provide affordable health care to all citizens.

"This assault on community hospitals is misdirected," said Dick Davidson, president of the American Hospital Association, which lobbies for the hospital industry, in an AHA press release. "We are confident the cases will be easily defeated and the resources of these hospitals will again be freed up to address the important mission each has in contributing to its community."

In August, the North Mississippi Medical Center in Tupelo agreed to provide free medical care to patients earning 200 percent FPL or less, and will offer discounts to uninsured patients with incomes up to four times the FPL. The hospital will also refund money or forgive debts to as many as 48,000 uninsured patients who received care during the past three years. The agreement is expected to save patients more than \$150 million. The hospital was never named in a suit, but it took the action to "avoid the distraction and cost of a potential suit." While David Merideth, co-counsel in the Scruggs lawsuits, calls the agreement "a beautiful template of what we hope to achieve," the American Hospital Association has not endorsed it.

Hospital Pricing Puts Uninsured at a Disadvantage

Nonprofit hospitals—which comprise 85 percent of the U.S. industry—certainly need enough revenue to keep their doors open, as they provide an important community service to thousands if not millions of Americans who cannot afford to pay at all.

Pennsylvania's uncompensated care burden is almost half a billion dollars annually, for example, while Georgia hospitals provide in excess of \$900 million in uncompensated care—including indigent and charity care—each year. In 2003, California's hospitals provided more than \$5 billion in uncompensated care; much of this cost was

incurred by treating the uninsured, according to C. Duane Dauner, president of the California Healthcare Association.

“Having more scrutiny of billing practices is a good thing, but the risk is we’re not taking on big tobacco, we’re taking on a vital service,” adds Rukavina. “It’s an industry I want to preserve, not bring down.”

Still, the philosophical question remains: Should these facilities be contributing to the hardship experienced by the uninsured and other vulnerable populations by charging them more?

Alan Weil, executive director of the National Academy for State Health Policy, agrees that uninsured patients are at a disadvantage the minute they walk into a hospital because charges to uninsured patients are much more varied. In many ways, he says, marking up the cost of services to uninsured patients is how the hospital makes up for costs lost to public payers and private insurance companies.

“If people feel deterred by the system that overcharges them, they are less likely to seek care—which creates a larger public health problem,” says Weil. “Because so few people pay charges, hospitals can pretty much charge whatever they want.” Studies have shown that people who put off needed care are more likely to develop chronic conditions that are even more expensive to treat. That behavior can add up to a financial drain on states, whose taxpayers will likely end up footing the bill.

But Paula Bussard, senior vice president of policy and regulatory services with the Hospital and Healthsystem Association of Pennsylvania, says that, despite the allegations, Pennsylvania hospitals do not expect payment from those eligible for charity care or financial assistance of any kind to exceed what they’re getting from other payers.

“If you were to call and ask individual hospitals, you would see that’s the practice,” Bussard says. “And since 70 percent of the hospitals in Pennsylvania lose money on patient care, they’re obviously providing a lot more patient care than the insurers and individuals have the wherewithal to pay for.”

According to Deborah Chollet, senior fellow at Mathematica Policy Research, Inc., states and counties may allocate funds to reimburse hospitals for all or some charity care; the rest of it is shifted to paying customers. In Pennsylvania, for example, hospitals that treat large numbers of uninsured patients may qualify for monies from the state’s tobacco settlement fund. The state makes about \$80 million available each year for payments to offset uncompensated care—far less than the hospitals’ burden.

Potential Solutions

A partial solution to the problem may be to make uninsured patients aware of their eligibility for financial assistance offered through the hospital. In Arkansas, for example, the ARKids program stations enrollment counselors in the patient enrollment offices of state hospitals to capture eligible individuals not enrolled in the program.

In several cases, uninsured patients allege that their bill would have been much more manageable had they been enrolled in programs that allow patients to pay using an installment plan, or in some cases to pay less for services. Some have suggested the hospitals do more work on the front end to ensure that all patients have access to the resources available to them, rather than employing tactics such as bill collection that may be construed as harassing and intimidating.

Merideth concedes that many hospitals have charity care policies in place, but argues that they are either deficient, inadequately implemented, or poorly communicated to the patient.

“An uninsured patient coming to the emergency room, for example, agrees to sign an admission agreement to be responsible for the bill without knowing what that bill will be, amounting to an open-ended promise to pay,” Merideth says. “A charity care notice sign is too passive a process to be effective in helping to connect uninsured patients with any financial help that the hospital may have available.”

Other individuals may be eligible for public programs such as Medicaid or Medicare, which would cover many of their costs. And there are examples of patients negotiating significant discounts, either with their doctors or with the hospital itself. In Virginia, for example, one patient negotiated with his cardiologist to reduce the charges from \$6,800 to about \$3,800, according to an article that appeared in the September 21, 2004, *Wall Street Journal*. However, many patients may not realize that the fees are flexible.

While no state legislation on hospital differential pricing passed in 2004, the fact that legislation was introduced shows that states are advocates of the uninsured and are taking steps to address the disparities they face. Whether there is political will for the enactment of similar proposals in 2005 remains to be seen. According to Sara Collins of The Commonwealth Fund, developing policies that would discourage hospitals from billing uninsured patients more than negotiated rates is a necessary step. However, “small policy changes will need to be accompanied by broad policy solutions that address the root cause of the affordability crisis in U.S. health care,” she says.

Resources

The Access Project – www.accessproject.org

The American Hospital Association – www.aha.org

The Center for Studying Health System Change – www.hschange.org

The Commonwealth Fund – www.cmwf.org

HealthLeaders Magazine – www.healthleaders.com/magazine

Physicians’ News Digest – www.physiciansnews.com



Highlights of Healthy New York

Established in 2001, Healthy New York (NY) targets the employers of middle- to low-wage workers, sole proprietors, and individuals. Employers can participate in the program if they:

- ◆ Have 50 or fewer employees;
- ◆ Have at least 30 percent of employees who earn less than \$33,000 annually (an amount that is adjusted each year);
- ◆ Do not offer or contribute substantially to comprehensive group coverage in the prior year;
- ◆ Contribute at least 50 percent of the premium for full-time workers; and
- ◆ Have participation in the program among at least half of eligible employees.

Sole proprietors and individuals may participate if the applicant (or his or her spouse):

- ◆ Is employed full- or part-time, or was employed during the prior year;
- ◆ Earns a gross household income that does not exceed 250 percent of the federal poverty level; and
- ◆ Is or has been uninsured for the past year and is ineligible for Medicare. The applicants with COBRA or public coverage may enroll directly in Healthy NY.

As of December 2004, Healthy New York had approximately 76,000 active enrollees. Approximately 60 percent of enrollees were working individuals, 20 percent sole proprietors, and 20 percent small-group employees.

The program contracts only with HMOs; 24 currently participate. All are required to enroll all applicants and to community rate—consistent with New York’s requirement that individual and small-group coverage throughout the state be guaranteed issue and “pure” community-rated. In addition, carriers are required to set a single premium for small groups, sole proprietors, and individuals, regardless of enrollment category.

Participating carriers may receive reimbursement for 90 percent of claims between \$5,000 and \$75,000 for any member in a calendar year. This risk corridor (the range of claims that participating carriers may reinsure) is lower than that which Healthy NY used when the program started, and represents an increase in funding and subsidies effective July 2003.

Resources

Healthy NY Web site,
www.ins.state.ny.us/website2/hny/english/hny.htm

2004 Annual Report on the Healthy NY Program, EP&P Consulting, Inc.
www.ins.state.ny.us/website2/hny/reports/hnyepp2004.pdf

2003 Annual Report on the Healthy NY Program, The Lewin Group
www.ins.state.ny.us/website2/hny/reports/hnylewin.pdf

Both Arizona and New York operate subsidized reinsurance programs, with the latter program enrolling almost 76,000 workers and their dependents. In Kansas, Governor Kathleen Sebelius (D) has proposed using reinsurance to provide an affordable insurance product to small employers, and other states have expressed interest in this strategy as they continue to try to shore up the private insurance market in their state.

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LOOKING AHEAD

As state officials enter 2005, they are uncertain about the road ahead. They have seen some hopeful signs pointing toward fiscal improvement, but don't know whether such trends will continue in 2005 and beyond, or if state and federal budgets will be adequate to fund public coverage programs or subsidize private insurance.

The Bush administration has indicated that its approach to addressing health care costs will be through establishing malpractice caps, creating health savings accounts (HSAs), and using disease management programs. It will attempt to broaden coverage by directing the uninsured to the individual market and association health plans and will reach out to low-income and high-risk individuals through expanded community health centers, a capped tax credit for the private, non-group market, and improved outreach to children eligible for Medicaid and the State Children's Health Insurance Program.

Where these health care strategies will fall in relation to other national priorities is not yet known. Most federal policymakers believe that the President's goal of cutting the burgeoning federal deficit will drive his coverage agenda, at least in the short term. Medicaid and Medicare will be forced under the budgetary microscope because significant deficit reduction cannot be achieved without changing them.

The nomination of Michael Leavitt, former administrator of the Environmental Protection Agency, to the position of Secretary of the Department of Health and Human Services, has also prompted much speculation regarding where the administration stands on Medicaid reform. Over the past decade, proposals to transform Medicaid, by turning it into a block grant program or implementing other sweeping changes, have arisen periodically—most recently in 2003, when discussions about block granting the program broke down. Many state officials are wary that a cataclysmic change may be in the offing, while others think that major national reforms are overdue or at least inevitable.

For now, no one knows whether Medicaid reform will happen at all and, if it does, what shape it will take. But any reform debate would likely stir controversy as it raises questions about the very nature of

the Medicaid program, including whether it can or should continue as an entitlement.

State officials were handed tremendous responsibility in 2004 with the passage of the Medicare Modernization Act (MMA). They played a critical role in implementing the drug discount card and are now focused on preparing for the Part D drug benefit, which will start in less than a year. To say that this is a challenging endeavor would be an understatement given the complexity of the program, the enormous number of critical decisions needing to be made about state pharmacy assistance programs, and the ambitious timeline.

MMA also created HSAs and further momentum for consumer-directed health care—the latest market-based strategy to controlling health care spending. Many plans have begun offering numerous options to consumers, and all eyes will be on them next year to see whether the plans will achieve take-up in the marketplace.

Whether states can expand health coverage is largely determined by whether they can control health care costs. Over the past decade, both market and regulatory approaches have been tried with limited success. Current strategies focus on changing health care spending at the individual level. Regardless of whether these or other recent efforts succeed, the fact that states are developing them in connection with their coverage strategies is encouraging; it demonstrates a growing recognition that the issues go hand in hand. The State Coverage Initiatives program pledges to work alongside state officials as they continue their journey to find alternate routes in expanding coverage.



New from SCI in 2004



The Role of Reinsurance in State Efforts to Expand Coverage October 2004

by Deborah Chollet
www.statecoverage.net/pdf/issuebrief1004.pdf



States' Issues and Concerns with Implementation of Medicare Part D Prescription Drug Coverage July 2004

www.statecoverage.net/pdf/medicarepartd.pdf



Health Savings Accounts: Issues and Implementation Decisions for States September 2004

by Mila Kofman, J.D.
www.statecoverage.net/pdf/issuebrief904.pdf



Pennsylvania's HIPP program

April 2004
by Isabel Friedenjohn and Jo Slesser
www.statecoverage.net/pennsylvaniaprofile.htm



ERISA Update: The Supreme Court Texas Decision and Other Recent Developments August 2004

by Patricia Butler
www.statecoverage.net/pdf/issuebrief804.pdf



State of the States 2004: Cultivating Hope in Rough Terrain January 2004

www.statecoverage.net/pdf/stateofstates2004.pdf



Limited-Benefit Policies: Public and Private-Sector Experiences July 2004

by Isabel Friedenjohn
www.statecoverage.net/pdf/issuebrief704.pdf



St@teside

In April, SCI launched its new monthly e-newsletter, St@teside. E-newsletter current editions and archives can be found at www.statecoverage.net/newsletters.htm.

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